7–13–09 Monday
Vol. 74 No. 132 July 13, 2009

Pages 33319–33900

Federal Register

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WHO: Sponsored by the Office of the Federal Register.

WHAT: Free public briefings (approximately 3 hours) to present:

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4. An introduction to the finding aids of the FR/CFR system.

WHY: To provide the public with access to information necessary to research Federal agency regulations which directly affect them. There will be no discussion of specific agency regulations.

WHEN: Tuesday, July 14, 2009
9:00 a.m.–12:30 p.m.

WHERE: Office of the Federal Register
Conference Room, Suite 700
800 North Capitol Street, NW.
Washington, DC 20002

RESERVATIONS: (202) 741–6008

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To subscribe to the Federal Register Table of Contents LISTSERV electronic mailing list, go to http://listserv.access.gpo.gov and select Online mailing list archives, FEDREGTOC-L, Join or leave the list (or change settings); then follow the instructions.

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DEPARTMENT OF AGRICULTURE

Natural Resources Conservation Service

7 CFR Part 650

RIN 0578–AA55

Compliance With NEPA

AGENCY: Natural Resources Conservation Service (NRCS), United States Department of Agriculture

ACTION: Interim final rule with request for comment.

SUMMARY: The Natural Resources Conservation Service (NRCS or the Agency) publishes this interim final rule to request comments on additional categorical exclusions, which are actions that the agency has determined do not individually or cumulatively have a significant effect on the human environment and, thus, should not require preparing an environmental assessment (EA) or environmental impact statement (EIS) under the National Environmental Policy Act (NEPA). NRCS' categorical exclusion actions promote restoration and conservation activities related to natural or human induced damage, or alteration of floodplain easements and watershed areas. For projects being funded under the American Recovery and Reinvestment Act of 2009 (ARRA), the interim final rule will assist NRCS in meeting mandates set forth in ARRA and NEPA for undertaking actions in the most expeditious manner and in compliance with NEPA.

DATES: *Effective Date:* The rule is effective July 13, 2009.

Comment date: Submit comments on or before September 11, 2009.

ADDRESSES: You may send comments (identified by Docket Number NRCS–0578–AA55) using any of the following methods:

- *Government-wide rulemaking Web site: http://www.regulations.gov* and follow the instructions for sending comments electronically.
- *E-mail: NEPA2008@wdc.usda.gov.*
- *Mail:* Matt Harrington, National Environmental Coordinator, Ecological Sciences Division, Department of Agriculture, Natural Resources Conservation Service, 1400 Independence Avenue, SW., Washington, DC 20250.
- *Fax:* (202) 720–2646.
- *Hand Delivery:* USDA South Building, 1400 Independence Avenue, SW., Room 6158, Washington, DC 20250, between 9 a.m. and 4 p.m., Monday through Friday, except Federal Holidays. Please ask the guard at the entrance to the South Building to call (202) 720–2587 in order to be escorted into the building.

This interim final rule may be accessed via Internet. Users can access the interim final rule at: *http://www.nrcs.usda.gov/programs/Env_Assess/index.html.* Persons with disabilities who require alternative means for communication (Braille, large print, audio tape, *etc.*) should contact the USDA TARGET Center at: (202) 720–2600 (voice and TDD).

FOR FURTHER INFORMATION CONTACT: Matt Harrington, National Environmental Coordinator, Ecological Sciences Division, Department of Agriculture, Natural Resources Conservation Service, 1400 Independence Avenue, SW., Washington DC 20250; Phone: (202) 720–4925; Fax: (202) 720–2646; or e-mail *NEPA2008@wdc.usda.gov*, and identify in the subject line, ''Information Requested.''

SUPPLEMENTARY INFORMATION:

Regulatory Certifications

Executive Order 12866

The Office of Management and Budget has determined that this interim final rule is a non-significant regulatory action under Executive Order 12866.

Regulatory Flexibility Act

Pursuant to 5 U.S.C. 605(c) of the Regulatory Flexibility Act, NRCS has determined that this interim final rule will not have a significant economic impact on a substantial number of small entities as defined by that Act. Therefore, a regulatory flexibility analysis is not required for this interim final rule.

Environmental Analysis

This interim final rule amends the procedures for implementing NEPA at 7 CFR part 650 and will not directly impact the environment. An agency's NEPA procedures are guidance to assist that agency in its fulfillment of responsibilities under NEPA, but are not that agency's final determination of what level of NEPA analysis is required for a particular action. The CEQ set forth the requirements for establishing agency NEPA procedures in its regulations at 40 CFR 1505.1 and 1507.3. The CEQ regulations do not require agencies to conduct NEPA analyses or prepare NEPA documentation when establishing their NEPA procedures. The determination that establishing agency NEPA procedures does not require NEPA analysis and documentation has been upheld in *Heartwood, Inc.* v. *U.S. Forest Service,* 230 F.3d 947, 954–55 (7th Cir. 2000).

Paperwork Reduction Act

There are no requirements for information collection associated with this interim final rule that would require approval under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

Unfunded Mandates Reform Act of 1995

NRCS assessed the effects of this rulemaking action on State, local, or Tribal governments and the public. This action does not compel the expenditure of $100 million or more in any one year (adjusted for inflation) by any State, local, or Tribal governments or anyone in the private sector; therefore, a statement under Section 202 of the Unfunded Mandates Reform Act of 1995 is not required.

Civil Justice Reform

This interim final rule has been reviewed under Executive Order 12988, Civil Justice Reform. After adoption of this interim final rule: (1) All State and local laws and regulations that conflict with this rule, or that would impede full implementation of this rule, will be preempted; (2) no retroactive effect would be given to this interim final rule; and (3) before an action may be brought in a Federal court of competent jurisdiction, the administrative appeal rights afforded persons at 7 CFR part 614 must be exhausted.

Federalism

NRCS has considered this interim final rule under the requirements of Executive Order 13132. NRCS has determined that this interim final rule would not impose any compliance costs on the States and would not have substantial direct effects on the States, on the relationship between the National Government and the States, nor on the distribution of power and responsibilities among the various levels of government. Therefore, NRCS has determined that this interim final rule conforms to the principles set forth in Executive Order 13132.

Energy Effects

NRCS has determined that this interim final rule does not constitute a significant energy action as defined in Executive Order 13211.

Background

NRCS finds that this amendment should proceed as an interim final rule. This interim final rule will facilitate the delivery of assistance under the ARRA for which timely delivery is of the essence. The actions identified have been subject to prior extensive environmental review that demonstrates that they do not individually or cumulatively have a significant effect on the human environment. The agency will evaluate each agency undertaking to ensure whether the undertaking meets the criteria of the categorical exclusion, or whether extraordinary circumstances exist which require additional environmental review. Given these safeguards, NRCS has determined that to proceed through a prior notice of proposed rulemaking would be impracticable, unnecessary, and contrary to the public interest in the efficient implementation of conservation programs.

I. National Environmental Policy Act

NEPA requires that Federal agencies consider the environmental effects or impacts of proposed Federal actions. NEPA requirements apply to any Federally funded or undertaken project, decision, or action, including grants. NEPA also established the Council on Environmental Quality (CEQ), which issued regulations at 50 CFR parts 1500–1508 implementing the procedural provisions of NEPA.

The CEQ regulations require Federal agencies to adopt their own implementing procedures to supplement the Council's regulations, and to establish and use categorical exclusions to define categories of actions that do not individually or cumulatively have a significant effect on the human environment and, therefore, do not require preparation of an EA or EIS (40 CFR 1507.3(b)(2)(ii) and 40 CFR 1508.4).

II. NRCS' Environmental Review Process

NRCS follows CEQ regulations for complying with NEPA. In addition, NRCS has supplemental regulations for NEPA compliance at 7 CFR part 650. Consistent with the CEQ regulations at 40 CFR 1508.4, NRCS defines ''categorical exclusion'' to mean ''a category of actions that does not individually or cumulatively have a significant effect on the human environment * * *'' and that has been found by NRCS to have no such effect. These supplemental regulations require that the Responsible Federal Official (RFO) must determine whether the proposed action fits within a categorical exclusion listed in the agency's implementing NEPA regulations (*see* 7 CFR 650.6(a)), and the proposed action does not involve any extraordinary circumstances (*see* 7 CFR 650.6(b)).

Section 650.6 currently identifies five actions that are categorically excluded from detailed review under NEPA. This interim final rule amends § 650.6 to identify an additional 21 actions as categorically excluded from detailed review through an EA or an EIS. Some of the new categorical exclusions are comparable in nature and scope to categorical exclusions of other Federal agencies. NRCS determined the new categorical exclusions routinely do not individually or cumulatively have a significant effect on the human environment. The statement supporting the categorical exclusions is available for review at the following Web site: *http://www.nrcs.usda.gov/programs/Env_Assess/index.html* or upon request from the NRCS National Environmental Coordinator.

NRCS has not updated its list of categorical exclusions since 1979. However, NRCS has over 70 years of experience (since the agency's establishment in 1935) with the actions being added to the agency's list of categorical exclusions. Based upon this experience and other data and analyses described below, NRCS has determined these actions as appropriate for incorporation in 7 CFR 650.6 as categorical exclusions.

As established in this interim final rule, NRCS will satisfy NEPA when using these categorical exclusions by determining whether a proposed agency action falls within the description of the activities and by reviewing the proposed agency action to determine whether extraordinary circumstances exist. In the event extraordinary circumstances exist, NRCS will prepare an EA or an EIS before proceeding with the proposed action (*see* 7 CFR 650.6(a) and (b)).

As noted in the statement supporting the categorical exclusions, NRCS provides support for each action being added to the categorical exclusion list by citing: (1) Other agencies that currently have categorical exclusions for actions which are comparable in nature to the action(s) NRCS is adding as new categorical exclusions; (2) the findings of the NRCS interdisciplinary teams' reviews, which are explained below; and (3) previous environmental reviews prepared by NRCS for these actions. By identifying these additional actions as categorical exclusions, NRCS is better able to meet the mandates of NRCS and CEQ NEPA regulations by providing for the efficient and timely environmental review of restoration and conservation activities. CEQ does not require agencies to prepare a NEPA analysis or document before establishing agency protocols or procedures that supplement the CEQ regulations for implementing NEPA.

III. NRCS Restoration and Conservation Planning

Since 1935, NRCS has assisted private individuals, conservation districts, Indian Tribes, units of government, and other organizations to apply conservation plans to conserve the Nation's natural resources, primarily on private agricultural lands. This is accomplished in partnership with locally led decision-making processes by providing conservation assistance through a national network of technically skilled, professional conservationists. These conservationists deliver consistent, science-based, site-specific solutions to help private landowners voluntarily conserve, maintain, and improve the Nation's natural resource base.

All NRCS actions are planned according to the requirements described in the NRCS National Planning Procedures Handbook. The Handbook prescribes that all planning be conducted through the use of a planning process, which includes the following nine steps:

1. Problem Identification.
2. Determine Objectives.
3. Inventory Resources.
4. Analyze Resource Data.
5. Formulate Alternatives.
6. Evaluate Alternatives.
7. Make Decisions.
8. Implement Plan.
9. Evaluate Plan.

NRCS conducts an Environmental Evaluation (EE), as required by 7 CFR

650.5, throughout the planning process, and incorporates environmental considerations throughout planning, installation, and operation of NRCS-assisted actions. By conducting the EE, NRCS is able to identify the appropriate level of environmental documentation and analysis required for a particular action.

Conservation practices are required to meet sustainable levels of quality criteria established in Section III of the Field Office Technical Guide (FOTG), for soil, water, air, plant, animal, and human resources. *See http://www.nrcs.usda.gov/technical/efotg/*. Additionally, all conservation practice implementation is governed by established conservation practice standards contained in Section IV of the FOTG.

The design and implementation of conservation practices must also meet technical and environmental criteria in NRCS manuals, handbooks, and publications, which in turn are developed through a peer and public review process.

NRCS obtains input about conservation practices from the State Technical Committees established pursuant to 16 U.S.C. 3861. NRCS also obtains public input about conservation practices by publishing in the **Federal Register** notice of any new conservation practice standard to be incorporated into the FOTG. In addition to State Technical Committee and **Federal Register** reviews, public participation is further accomplished through coordinating the implementation of NRCS activities with local Soil and Water Conservation Districts (SWCD). SWCD board members are comprised of local landowners, elected by the public, to represent community interests, advocate conservation, assist NRCS in setting local resource priorities, and approving conservation plans. All technical and financial assistance provided by NRCS is voluntary and is provided in partnership with the local SWCD at the request of an individual, unit of government, Indian Tribe, or sponsoring organization.

IV. Process Used To Identify the Categorical Exclusions

For all the actions added to 7 CFR 650.6 as categorical exclusions and described below, NRCS convened a group of interdisciplinary experts to review agency actions and determine whether the actions should be considered as a new categorical exclusion based upon their experience, expertise, and environmental review. The interdisciplinary team also considered comparable categorical exclusions from other agencies throughout the Federal Government that conduct similar activities under similar circumstances. In addition to the interdisciplinary team, NRCS also collected environmental review information from a sample of its State and field offices that have undertaken these actions over the past 70 years. The State and field offices providing information were: California, Colorado, Georgia, Iowa, Kentucky, Louisiana, Massachusetts, Missouri, Nebraska, New Hampshire, Oklahoma, Oregon, Rhode Island, and Texas. Overall, the environmental documentation information reported by these States showed that implementation of these categorical exclusions has not resulted in individually or cumulatively significant environmental effects.

These 14 States provided a random sample of conservation activities, and coincidentally these random samples encompassed agency actions within 11 of the 12 major river basins in the continental United States. Concurrent with the public comment period, NRCS is requesting information to be submitted from State and field offices within the remaining 12th river basin [Great Lakes River Basin] which includes: Illinois, Indiana, Michigan, Minnesota, New York, Ohio, Pennsylvania, and Wisconsin, and will incorporate any additional information gained from this input and public comment in the development of the final rule. The information provided in the statement supporting the categorical exclusions includes Damage Survey Reports containing an EE, EA, and EIS prepared over a 9-year period (2000–2009) for the actions to be categorically excluded.

V. Categorical Exclusions for Restoration and Conservation Actions

All the actions identified as a categorical exclusion below require documentation in accordance with 7 CFR 650.6 that address whether extraordinary circumstances are determined to exist. Furthermore, the following categorical exclusions only apply to proposed actions that: (1) Include provisions to mitigate soil erosion, sedimentation, and downstream flooding; (2) require disturbed areas to be vegetated with adapted species; (3) are based on the principles of natural stream dynamics and processes presented in the Federal Interagency Stream Corridor Restoration Working Group document (*http://www.nrcs.usda.gov/technical/stream_restoration/*), ''Stream Corridor Restoration, Principles, Processes, and Practices;'' (4) incorporate the applicable NRCS conservation practice standards as found in the FOTG [*http://www.nrcs.usda.gov/technical/efotg/*]; (5) do not require substantial dredging, excavation, or placement of fill; and (6) do not involve a significant risk of exposure to toxic or hazardous substances.

The identification of these actions as categorical exclusions under NEPA does not relinquish the responsibility of NRCS to comply with the mandatory consultation requirements under the National Historic Preservation Act and implementing regulations, the Endangered Species Act and implementing regulations, and any other legal requirements.

The following actions are being added to 7 CFR 650.6 as categorical exclusions:

1. Planting appropriate herbaceous and/or woody vegetation on disturbed sites to restore and/or maintain the site's pre-disturbance vegetative community or similar adaptive naturalized vegetative community that provides analogous ecological functions and services;

2. Removing dikes and associated appurtenances (such as culverts, pipes, valves, gates, and fencing) to allow waters to access floodplains to the extent that had existed prior to the installation of such dikes and associated appurtenances;

3. Plugging and filling excavated drainage ditches to allow hydrologic conditions to return to pre-drainage conditions to the extent practicable;

4. Replacing and repairing existing culverts, grade stabilization, and water control structures and other small structures that were damaged by natural disasters where there is no new depth required and only minimal dredging, excavation, or placement of fill is required;

5. Restoring the natural topographic features of agricultural fields that were altered by farming and ranching activities for the purpose of restoring ecological processes;

6. Removing or relocating residential, commercial, and other public and private buildings and associated structures constructed in the 100-year floodplain or within the breach inundation area of an existing dam or other flood control structure in order to restore natural hydrologic conditions of inundation or saturation, vegetation, or reduce hazards posed to public safety;

7. Removing storm debris and sediment following a natural disaster where there is a continuing and eminent threat to public health or safety, property, and/or natural and cultural resources and removal is necessary to restore lands to pre-disaster conditions

to the extent practicable. Excavation shall not exceed the pre-disaster condition;

8. Stabilizing stream banks and associated structures to reduce erosion through bioengineering techniques following a natural disaster to restore pre-disaster conditions to the extent practicable (*e.g.,* utilization of living and nonliving plant materials in combination with natural and synthetic support materials, such as rocks, rip-rap, and geo-textiles, for slope stabilization, erosion reduction, and vegetative establishment) and establishment of appropriate plant communities (bank shaping and planting, brush mattresses, log, root wad, and boulder stabilization methods);

9. Repairing or maintenance of existing small structures or improvements (including structures and improvements utilized to restore disturbed or altered wetland, riparian, in stream, or native habitat conditions). Examples of such activities include the repair or stabilization of existing stream crossings for livestock or human passage, levees, culverts, berms, dikes, and associated appurtenances;

10. Constructing small structures or improvements for the restoration of wetland, riparian, in stream, or native habitats. Examples of activities include: (1) Installation of fences, and (2) construction of small berms, dikes, and associated water control structures;

11. Restoring an ecosystem, fish and wildlife habitat, biotic community, or population of living resources to a determinable pre-impact condition;

12. Repairing or maintenance of existing constructed fish passageways, such as fish ladders or spawning areas, impacted by natural disasters or human alteration;

13. Repairing, maintaining, or installing fish screens to existing structures;

14. Repairing or maintaining principal spillways and appurtenances associated with existing serviceable dams, originally constructed to NRCS standards, in order to meet current safety standards. Work will be confined to the existing footprint of the dam, and no major change in reservoir or downstream operations will result;

15. Repairing or improving (deepening/widening/armoring) existing auxiliary/emergency spillways associated with dams, originally constructed to NRCS standards, in order to meet current safety standards. Work will be confined to the dam or abutment areas, and no major change in reservoir or downstream operation will result;

16. Repairing embankment slope failures on structures originally built to NRCS standards where the work is confined to the embankment or abutment areas;

17. Increasing the freeboard (which is the height from the auxiliary (emergency) spillway crest to the top of embankment) of an existing dam or dike, originally built to NRCS standards by raising the top elevation in order to meet current safety and performance standards. The purpose of the safety standard and associated work is to ensure that during extreme rainfall events, flows are confined to the auxiliary/emergency spillway so that the existing structure is not overtopped which may result in a catastrophic failure. Elevating the top of the dam will not result in an increase to lake or stream levels. Work will be confined to the existing dam and abutment areas, and no major change in reservoir operations will result. Examples of work may include the addition of fill material such as earth or gravel, or placement of parapet walls;

18. Modifying existing residential, commercial, and other public and private buildings to prevent flood damages, such as elevating structures or sealing basements to comply with current State safety standards and Federal performance standards;

19. Undertaking minor agricultural practices to maintain and/or restore ecological conditions in floodplains after a natural disaster or on lands impacted by human alteration. Examples of these practices include: mowing, haying, grazing, fencing, off-stream watering facilities, and invasive species control which are undertaken when fish and wildlife are not breeding, nesting, rearing young, or during other sensitive timeframes;

20. Implementing soil erosion control measures on existing agricultural lands, such as grade stabilization structures (pipe drops), sediment basins, terraces, grassed waterways, filter strips, riparian forest buffer, and critical area planting; and

21. Implementing water conservation activities on existing agricultural lands, such as minor irrigation land leveling, irrigation water conveyance (pipelines), irrigation water control structures, and various management practices.

In addition to identifying these actions as categorical exclusions, NRCS is making editorial adjustments to § 650.6 to clarify the process that applies to the programs originally identified as categorical exclusions under § 650.6(a), and the new categorical exclusions identified in a new paragraph (c). In particular, paragraph (b) of § 650.6 is revised to indicate that the procedures identified therein apply specifically to the programs identified in paragraph (a).

The public is invited to submit comments on both the ''The Statement Supporting the Proposed Categorical Exclusions'' and the categorical exclusions listed above. *See* the **ADDRESSES** for instructions on submitting comments. ''The Statement Supporting the Proposed Categorical Exclusions'' is available at *http://www.nrcs.usda.gov/programs/Env_Assess/index.html* under ''NRCS' Proposed Expanded List of Categorical Exclusions.'' In addition, hard copies may be obtained by contacting the NRCS National Environmental Coordinator, as provided above.

List of Subjects in 7 CFR Part 650

Environmental impact statements, Flood plains.

■ For the reasons stated in the preamble, NRCS amends part 650 of Title 7 of the Code of Federal Regulations as set forth below:

PART 650—COMPLIANCE WITH NEPA

■ 1. The authority citation for part 650 is amended to read as follows:

Authority: 42 U.S.C. 4321 *et seq.;* Executive Order 11514 (Rev.); 7 CFR 2.62, unless otherwise noted.

■ 2. Section 650.6 is amended by revising paragraph (b) and adding a new paragraph (c) to read as follows:

§ 650.6 Categorical Exclusions

* * * * *

(b) When any new action is planned under the programs identified in paragraph (a) of this section, the EE performed by the RFO is to identify extraordinary circumstances that might lead to significant individual or cumulative impacts. Actions that have potential for significant impacts on the human environment are not categorically excluded.

(c) The NRCS restoration and conservation actions and activities identified in this paragraph (c) are eligible for categorical exclusion and require the RFO to document a determination that a categorical exclusion applies. Agency personnel will use the EE review process to evaluate proposed activities for significant impacts and extraordinary circumstances using the significance criteria provided in 40 CFR 1508.27. In the absence of any extraordinary circumstances as determined through NRCS' EE review process, the activities will be able to proceed without preparation of an EA or EIS. Where

either significant impacts or extraordinary circumstances are determined to exist, the categorical exclusion will not apply and the appropriate documentation for compliance with NEPA will be prepared. The following actions are eligible for categorical exclusion:

(1) Planting appropriate herbaceous and/or woody vegetation on disturbed sites to restore and/or maintain the site's pre-disturbance vegetative community or similar adaptive naturalized vegetative community that provides analogous ecological functions and services;

(2) Removing dikes and associated appurtenances (such as culverts, pipes, valves, gates, and fencing) to allow waters to access floodplains to the extent that had existed prior to the installation of such dikes and associated appurtenances;

(3) Plugging and filling excavated drainage ditches to allow hydrologic conditions to return to pre-drainage conditions to the extent practicable;

(4) Replacing and repairing existing culverts, grade stabilization, and water control structures and other small structures that were damaged by natural disasters where there is no new depth required and only minimal dredging, excavation, or placement of fill is required;

(5) Restoring the natural topographic features of agricultural fields that were altered by farming and ranching activities for the purpose of restoring ecological processes;

(6) Removing or relocating residential, commercial, and other public and private buildings and associated structures constructed in the 100-year floodplain or within the breach inundation area of an existing dam or other flood control structure in order to restore natural hydrologic conditions of inundation or saturation, vegetation, or reduce hazards posed to public safety;

(7) Removing storm debris and sediment following a natural disaster where there is a continuing and eminent threat to public health or safety, property, and/or natural and cultural resources and removal is necessary to restore lands to pre-disaster conditions to the extent practicable. Excavation shall not exceed the pre-disaster condition;

(8) Stabilizing stream banks and associated structures to reduce erosion through bioengineering techniques following a natural disaster to restore pre-disaster conditions to the extent practicable, *e.g.,* utilization of living and nonliving plant materials in combination with natural and synthetic support materials, such as rocks, rip-rap, geo-textiles, for slope stabilization, erosion reduction, and vegetative establishment) and establishment of appropriate plant communities (bank shaping and planting, brush mattresses, log, root wad, and boulder stabilization methods);

(9) Repairing or maintenance of existing small structures or improvements (including structures and improvements utilized to restore disturbed or altered wetland, riparian, in stream, or native habitat conditions). Examples of such activities include the repair or stabilization of existing stream crossings for livestock or human passage, levees, culverts, berms, dikes, and associated appurtenances;

(10) Constructing small structures or improvements for the restoration of wetland, riparian, in stream, or native habitats. Examples of activities include:

(i) Installation of fences, and

(ii) Construction of small berms, dikes, and associated water control structures;

(11) Restoring an ecosystem, fish and wildlife habitat, biotic community, or population of living resources to a determinable pre-impact condition;

(12) Repairing or maintenance of existing constructed fish passageways, such as fish ladders or spawning areas impacted by natural disasters or human alteration;

(13) Repairing, maintaining, or installing fish screens to existing structures;

(14) Repairing or maintaining principal spillways and appurtenances associated with existing serviceable dams, originally constructed to NRCS standards, in order to meet current safety standards. Work will be confined to the existing footprint of the dam, and no major change in reservoir or downstream operations will result;

(15) Repairing or improving (deepening/widening/armoring) existing auxiliary/emergency spillways associated with dams, originally constructed to NRCS standards, in order to meet current safety standards. Work will be confined to the dam or abutment areas, and no major change in reservoir or downstream operation will result;

(16) Repairing embankment slope failures on structures originally built to NRCS standards where the work is confined to the embankment or abutment areas;

(17) Increasing the freeboard (which is the height from the auxiliary (emergency) spillway crest to the top of embankment) of an existing dam or dike, originally built to NRCS standards by raising the top elevation in order to meet current safety and performance standards. The purpose of the safety standard and associated work is to ensure that during extreme rainfall events, flows are confined to the auxiliary/emergency spillway so that the existing structure is not overtopped which may result in a catastrophic failure. Elevating the top of the dam will not result in an increase to lake or stream levels. Work will be confined to the existing dam and abutment areas, and no major change in reservoir operations will result. Examples of work may include the addition of fill material, such as earth or gravel, or placement of parapet walls;

(18) Modifying existing residential, commercial, and other public and private buildings to prevent flood damages, such as elevating structures or sealing basements to comply with current State safety standards and Federal performance standards;

(19) Undertaking minor agricultural practices to maintain and/or restore ecological conditions in floodplains after a natural disaster or on lands impacted by human alteration. Examples of these practices include: Mowing, haying, grazing, fencing, off-stream watering facilities, and invasive species control, which are undertaken when fish and wildlife are not breeding, nesting, rearing young, or during other sensitive timeframes;

(20) Implementing soil control measures on existing agricultural lands, such as grade stabilization structures (pipe drops), sediment basins, terraces, grassed waterways, filter strips, riparian forest buffer, and critical area planting; and

(21) Implementing water conservation activities on existing agricultural lands, such as minor irrigation land leveling, irrigation water conveyance (pipelines), irrigation water control structures, and various management practices.

* * * * *

Signed this 7th day of July, 2009, in Washington, DC.

Dave White,

Chief, Natural Resources Conservation Service.

[FR Doc. E9–16400 Filed 7–10–09; 8:45 am]

BILLING CODE 3410–16–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 23

[Docket No. CE298; Special Condition No. 23–238–SC]

Special Conditions: Maule Aerospace Technology, Inc.; Maule Model M–7–230, M–7–230C, and M–9–230 Airplanes; Diesel Cycle Engine Using Turbine (Jet) Fuel

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final special conditions; request for comments.

SUMMARY: These special conditions are issued for the Maule Model M–7–230, M–7–230C, and M–9–230 airplanes with a Societe de Motorisation Aeronautiques (SMA) Model SR305–230 aircraft diesel engine (ADE). This airplane will have a novel or unusual design feature(s) associated with the installation of a diesel cycle engine utilizing turbine (jet) fuel. The applicable airworthiness regulations do not contain adequate or appropriate safety standards for installation of this new technology engine. These special conditions contain the additional safety standards that the Administrator considers necessary to establish a level of safety equivalent to that established by the existing airworthiness standards.

DATES: The effective date of these special conditions is July 2, 2009.

We must receive your comments by August 12, 2009.

ADDRESSES: Mail two copies of your comments to: Federal Aviation Administration, Regional Counsel, ACE–7, Attention: Rules Docket CE298, 901 Locust, Room 506, Kansas City, Missouri 64106. You may deliver two copies to the Rules Docket at the above address. Mark your comments Docket No. CE298. You may inspect comments in the Rules Docket weekdays, except Federal holidays, between 7:30 a.m. and 4 p.m.

FOR FURTHER INFORMATION CONTACT: Peter L. Rouse, Federal Aviation Administration, Aircraft Certification Service, Small Airplane Directorate, ACE–111, 901 Locust, Kansas City, Missouri, 816–329–4135, fax 816–329–4090.

SUPPLEMENTARY INFORMATION: The FAA has determined that notice and opportunity for prior public comment hereon are impracticable because these procedures would significantly delay issuance of the design approval and thus delivery of the affected aircraft. In addition, the substance of these special conditions has been subject to the public comment process in several prior instances with no substantive comments received. The FAA, therefore, finds that good cause exists for making these special conditions effective upon issuance.

Comments Invited

We invite interested persons to take part in this rulemaking by sending written comments, data, or views. The most helpful comments reference a specific portion of the special conditions, explain the reason for any recommended change, and include supporting data. We ask that you send us two copies of written comments.

We will file in the docket all comments we receive, as well as a report summarizing each substantive public contact with FAA personnel about these special conditions. You may inspect the docket before and after the comment closing date. If you wish to review the docket in person, go to the address in the **ADDRESSES** section of this preamble between 7:30 a.m. and 4 p.m. Monday through Friday, except Federal holidays.

We will consider all comments we receive by the closing date for comments. We will consider comments filed late if it is possible to do so without incurring expense or delay. We may change these special conditions based on the comments we receive.

If you want us to let you know we received your comments on these special conditions, send us a pre-addressed, stamped postcard on which the docket number appears. We will stamp the date on the postcard and mail it back to you.

Background

On July 16, 2007, Maule Aerospace Technology, Inc., applied through the Atlanta Aircraft Certification Office to amend Type Certificate 3A23 by certifying derivative Maule airplane Models M–7–230, M–7–230C, and M–9–230 to include the installation of a Societe de Motorisation Aeronautiques (SMA) Model SR305–230 aircraft diesel engine. The SMA Model SR305–230 aircraft diesel engine was previously type certificated in the United States under type certificate number E00067EN.

In anticipation of the reintroduction of diesel engine technology into the small airplane fleet, the FAA issued Policy Statement PS–ACE100–2002–004 on May 15, 2004, which identified areas of technological concern involving introduction of new technology diesel engines into small airplanes. For a more detailed summary of the FAA's development of diesel engine requirements, refer to this policy.

The general areas of concern involved the power characteristics of the diesel engines, the use of turbine fuel in an airplane class that has typically been powered by gasoline fueled engines, and the vibration characteristics and failure modes of diesel engines. These concerns were identified after review of the historical record of diesel engine used in aircraft and a review of the 14 CFR part 23 regulations, which identified specific regulatory areas that needed to be evaluated for applicability to diesel engine installations. These concerns are not considered universally applicable to all types of possible diesel engines and diesel engine installations. However, after review of the SMA installation on the Maule Airplane, and applying the provisions of the diesel policy, the FAA proposes these fuel system and engine related special conditions. Other special conditions issued in a separate notice include special conditions for HIRF and application of § 23.1309 provisions to the Full Authority Digital Engine Control (FADEC).

Type Certification Basis

Under the provisions of § 21.101, Maule Aerospace Technology, Inc., must show that the Maule Model M–7–230, M–7–230C, and M–9–230 airplanes with the installation of an SMA Model SR305–230 meet the applicable provisions of 14 CFR part 23, as amended by Amendments 23–1 through 23–55 and Civil Air Regulations (CAR) 3 thereto. In addition, the certification basis includes special conditions and equivalent levels of safety for the following:

Special Conditions

- Engine torque (Provisions similar to § 23.361, paragraphs (b)(1) and (c)(3)).
- Flutter (Compliance with § 23.629, paragraphs (e)(1) and (2)).
- Powerplant—Fuel System—Fuel system with water saturated fuel. (Compliance with § 23.951 requirements.)
- Powerplant—Fuel System—Fuel system hot weather operation. (Compliance with § 23.961 requirements.)
- Powerplant—Fuel system—Fuel tank filler connection. (Compliance with § 23.973(f) requirements.)
- Powerplant—Fuel system—Fuel tank outlet. (Compliance with § 23.977 requirements.)
- Equipment—General—Powerplant Instruments. (Compliance with § 23.1305 requirements.)

• Operating Limitations and Information—Powerplant limitations—Fuel grade or designation. (Compliance with § 23.1521(d) requirements.)

• Markings and Placards—Miscellaneous markings and placards—Fuel, oil, and coolant filler openings. (Compliance with § 23.1557(c)(1) requirements.)

• Powerplant—Fuel system—Fuel Freezing.

• Powerplant Installation—One cylinder inoperative.

• Powerplant Installation—High Energy Engine Fragments.

Equivalent levels of safety for:

• Ignition switches § 23.1145

The type certification basis includes exemptions, if any; equivalent level of safety findings, if any; and the special conditions adopted by this rulemaking action.

If the Administrator finds that the applicable airworthiness regulations (*i.e.*, part 23) do not contain adequate or appropriate safety standards for the Maule Model M–7–230, M–7–230C, and M–9–230 airplanes with the installation of an SMA Model SR305–230 ADE because of a novel or unusual design feature, special conditions are prescribed under the provisions of § 21.16.

In addition to the applicable airworthiness regulations and special conditions, the Maule Model M–7–230, M–7–230C, and M–9–230 airplanes with the installation of an SMA Model SR305–230 ADE must comply with the noise certification requirements of 14 CFR part 36.

The FAA issues special conditions, as appropriate, as defined in § 11.19, under § 11.38, and they become part of the type certification basis under § 21.101.

Special conditions are initially applicable to the model for which they are issued. Should the applicant apply for a supplemental type certificate or amended type certificate to modify any other model included on the same type certificate to incorporate the same novel or unusual design feature, the special conditions would also apply to the other model under the provisions of § 21.101.

Novel or Unusual Design Features

The Maule Model M–7–230, M–7–230C, and M–9–230 airplanes with the installation of an SMA Model SR305–230 ADE will incorporate the following novel or unusual design features: The Maule Model M–7–230, M–7–230C, and M–9–230 airplanes with the installation of an SMA Model SR305–230 ADE will incorporate an aircraft diesel engine utilizing turbine (jet) fuel.

Applicability

As discussed above, these special conditions are applicable to the Maule Model M–7–230, M–7–230C, and M–9–230 airplanes with the installation of an SMA Model SR305–230 ADE. Should Maule apply at a later date for a change to the type certificate to modify any other model included on Type Certificate No. 3A23 to incorporate the same novel or unusual design feature, the special conditions would apply to that model as well.

Conclusion

Under standard practice, the effective date of final special conditions would be 30 days after the date of publication in the **Federal Register**; however, as the certification date for the Maule Model M–7–230, M–7–230C, and M–9–230 airplanes is imminent, the FAA finds that good cause exists to make these special conditions effective upon issuance.

This action affects only certain novel or unusual design features on the Maule Model M–7–230, M–7–230C, and M–9–230 airplanes with the installation of an SMA Model SR305–230 ADE. It is not a rule of general applicability, and it affects only the applicant who applied to the FAA for approval of these features on the airplane.

List of Subjects in 14 CFR Part 23

Aircraft, Aviation safety, Signs and symbols.

Citation

■ The authority citation for these special conditions is as follows:

Authority: 49 U.S.C. 106(g), 40113 and 44701; 14 CFR 21.16, and 21.101; and 14 CFR 11.38 and 11.19.

The Special Conditions

Accordingly, pursuant to the authority delegated to me by the Administrator, the following special conditions are issued as part of the type certification basis for the Maule Model M–7–230, M–7–230C, and M–9–230 airplanes with the installation of an SMA Model SR305–230 ADE.

1. Engine torque (Provisions similar to § 23.361, paragraphs (b)(1) and (c)(3)):

(a) For diesel engine installations, the engine mounts and supporting structure must be designed to withstand the following:

(1) A limit engine torque load imposed by sudden engine stoppage due to malfunction or structural failure.

The effects of sudden engine stoppage may alternately be mitigated to an acceptable level by utilization of isolators, dampers, clutches and similar provisions, so that unacceptable load levels are not imposed on any structure.

(b) The limit engine torque obtained in CAR 3.195(a)(1) and (a)(2) or 14 CFR § 23.361(a)(1) and (a)(2) must be obtained by multiplying the mean torque by a factor of four in lieu of the factor of two required by CAR 3.195(b) and 14 CFR § 23.361(c)(3).

2. Flutter—(Compliance with § 23.629 (e)(1) and (e)(2) requirements):

The flutter evaluation of the airplane done in accordance with 14 CFR § 23.629 must include—

(a) Whirlmode degree of freedom which takes into account the stability of the plane of rotation of the propeller and significant elastic, inertial, and aerodynamic forces, and

(b) Propeller, engine, engine mount and airplane structure stiffness and damping variations appropriate to the particular configuration, and

(c) Showing the airplane is free from flutter with one cylinder inoperative.

3. Powerplant—Fuel System—Fuel system with water saturated fuel (Compliance with § 23.951 requirements):

Considering the fuel types used by diesel engines, the applicant must comply with the following:

Each fuel system for a diesel engine must be capable of sustained operation throughout its flow and pressure range with fuel initially saturated with water at 80 °F and having 0.75cc of free water per gallon added and cooled to the most critical condition for icing likely to be encountered in operation.

Methods of compliance that are acceptable for turbine engine fuel systems requirements of § 23.951(c) are also considered acceptable for this requirement.

4. Powerplant—Fuel System—Fuel flow (Compliance with § 23.955(c) requirements):

In lieu of 14 CFR 23.955(c), engine fuel system must provide at least 100 percent of the fuel flow required by the engine, or the fuel flow required to prevent engine damage, if that flow is greater than 100 percent. The fuel flow rate must be available to the engine under each intended operating condition and maneuver. The conditions may be simulated in a suitable mockup. This flow must be shown in the most adverse fuel feed condition with respect to altitudes, attitudes, and any other condition that is expected in operation.

5. Powerplant—Fuel System—Fuel system hot weather operation (Compliance with § 23.961 requirements):

In place of compliance with § 23.961, the applicant must comply with the following:

Each fuel system must be free from vapor lock when using fuel at its critical temperature, with respect to vapor formation, when operating the airplane in all critical operating and environmental conditions for which approval is requested. For turbine fuel, or for aircraft equipped with diesel cycle engines that use turbine or diesel type fuels, the initial temperature must be 110 °F, -0°, +5° or the maximum outside air temperature for which approval is requested, whichever is more critical.

The fuel system must be in an operational configuration that will yield the most adverse, that is, conservative results.

To comply with this requirement, the applicant must use the turbine fuel requirements and must substantiate these by flight-testing, as described in Advisory Circular AC 23–8B, Flight Test Guide for Certification of Part 23 Airplanes.

6. Powerplant—Fuel system—Fuel tank filler connection (Compliance with § 23.973(f) requirements):

In place of compliance with § 23.973(e) and (f), the applicant must comply with the following:

For airplanes that operate on turbine or diesel type fuels, the inside diameter of the fuel filler opening must be no smaller than 2.95 inches.

7. Powerplant—Fuel system—Fuel tank outlet (Compliance with § 23.977 requirements):

In place of compliance with § 23.977(a)(1) and (a)(2), the applicant will comply with the following:

There must be a fuel strainer for the fuel tank outlet or for the booster pump. This strainer must, for diesel engine powered airplanes, prevent the passage of any object that could restrict fuel flow or damage any fuel system component.

8. Equipment—General—Powerplant Instruments (Compliance with § 23.1305):

In addition to compliance with § 23.1305, the applicant will comply with the following:

The following are required in addition to the powerplant instruments required in § 23.1305:

(a) A fuel temperature indictor, or

(b) An outside air temperature (OAT) indicator.

(c) An indicating means for the fuel strainer or filter required by § 23.997 to indicate the occurrence of contamination of the strainer or filter before it reaches the capacity established in accordance with § 23.997(d).

Alternately, no indicator is required if the engine can operate normally for a specified period with the fuel strainer exposed to the maximum fuel contamination as specified in MIL–5007D and provisions for replacing the fuel filter at this specified period (or a shorter period) are included in the maintenance schedule for the engine installation.

9. Operating Limitations and Information—Powerplant limitations—Fuel grade or designation (Compliance with § 23.1521 requirements):

All engine parameters that have limits specified by the engine manufacturer for takeoff or continuous operation must be investigated to ensure they remain within those limits throughout the expected flight and ground envelopes (*e.g.*, maximum and minimum fuel temperatures, ambient temperatures, as applicable, *etc.*). This is in addition to the existing requirements specified by 14 CFR 23.1521(b) and (c). If any of those limits can be exceeded, there must be continuous indication to the flight crew of the status of that parameter with appropriate limitation markings.

Instead of compliance with § 23.1521(d), the applicant must comply with the following:

The minimum fuel designation (for diesel engines) must be established so that it is not less than that required for the operation of the engines within the limitations in paragraphs (b) and (c) of § 23.1521.

10. Markings and Placards—Miscellaneous markings and placards—Fuel, oil, and coolant filler openings (Compliance with § 23.1557(c)(1) requirements):

Instead of compliance with § 23.1557(c)(1), the applicant must comply with the following:

Fuel filler openings must be marked at or near the filler cover with—

For diesel engine-powered airplanes—

(a) The words ''Jet Fuel''; and

(b) The permissible fuel designations, or references to the Airplane Flight Manual (AFM) for permissible fuel designations.

(c) A warning placard or note that states the following or similar:

''Warning—this airplane equipped with an aircraft diesel engine, service with approved fuels only.''

The colors of this warning placard should be black and white.

11. Powerplant—Fuel system—Fuel-Freezing:

If the fuel in the tanks cannot be shown to flow suitably under all possible temperature conditions, then fuel temperature limitations are required. These will be considered as part of the essential operating parameters for the aircraft and must be limitations.

A minimum takeoff temperature limitation will be determined by testing to establish the minimum cold-soaked temperature at which the airplane can operate. The minimum operating temperature will be determined by testing to establish the minimum operating temperature acceptable after takeoff from the minimum takeoff temperature. If low temperature limits are not established by testing, then a minimum takeoff and operating fuel temperature limit of 5 °F above the gelling temperature of Jet A will be imposed. The low temperature limit may be 5 °F above the gelling temperature of Jet A with fuel additives, if the additives are included in the limitations section of the Airplane Flight Manual. A display in the cockpit of either fuel temperature or outside temperature is required.

12. Powerplant Installation—One cylinder inoperative:

It must be shown by test or analysis, or by a combination of methods, that the airframe can withstand the shaking or vibratory forces imposed by the engine if a cylinder becomes inoperative. Diesel engines of conventional design typically have extremely high levels of vibration when a cylinder becomes inoperative.

No unsafe condition will exist in the case of an inoperative cylinder before the engine can be shut down. The resistance of the airframe structure, propeller, and engine mount to shaking moment and vibration damage must be investigated. It must be shown by test or analysis, or by a combination of methods, that shaking and vibration damage from the engine with an inoperative cylinder will not cause a catastrophic airframe, propeller, or engine mount failure.

13. Powerplant Installation—High Energy Engine Fragments:

It may be possible for diesel engine cylinders (or portions thereof) to fail and physically separate from the engine at high velocity (due to the high internal pressures). This failure mode will be considered possible in engine designs with removable cylinders or other non-integral block designs. The following is required:

(1) It must be shown by the design of the engine that engine cylinders, other engine components or portions thereof (fragments) cannot be shed or blown off of the engine in the event of a catastrophic engine failure; or

(2) It must be shown that all possible liberated engine parts or components do not have adequate energy to penetrate engine cowlings; or

(3) Assuming infinite fragment energy, and analyzing the trajectory of the probable fragments and components, any hazard due to liberated engine parts or components will be minimized and the possibility of crew injury eliminated. Minimization must be considered during initial design and not presented as an analysis after design completion.

Issued in Kansas City, Missouri, on July 2, 2009.

Scott A. Horn,

Acting Manager, Small Airplane Directorate, Aircraft Certification Service.

[FR Doc. E9–16476 Filed 7–10–09; 8:45 am]

BILLING CODE 4910–13–P

SOCIAL SECURITY ADMINISTRATION

20 CFR Parts 404 and 416

[Docket No. SSA–2009–0023]

RIN 0960–AH01

Attorney Advisor Program Sunset Date Extension

AGENCY: Social Security Administration.

ACTION: Final rule.

SUMMARY: We are extending for two years our rule authorizing attorney advisors to conduct certain prehearing procedures and to issue fully favorable decisions. The current rule is scheduled to expire on August 10, 2009. In this final rule, we are extending the sunset date to August 10, 2011. We are making no other substantive changes.

DATES: This final rule is effective July 13, 2009.

FOR FURTHER INFORMATION CONTACT: Marilyn Hull, Social Security Administration, 5107 Leesburg Pike, Falls Church, VA 22041–3260, 703–605–8500 for information about this final rule. For information on eligibility or filing for benefits, call our national toll-free number, 1–800–772–1213 or TTY 1–800–325–0778, or visit our Internet site, Social Security Online, at *http://www.socialsecurity.gov.*

SUPPLEMENTARY INFORMATION:

Electronic Version

The electronic file of this document is available on the date of publication in the **Federal Register** at *http://www.gpoaccess.gov/fr/index.html.*

Background

On August 9, 2007, we issued an interim final rule permitting some attorney advisors to conduct certain prehearing procedures. 72 FR 44763. We instituted this practice to enable us to provide more timely service to the increasing number of applicants for Social Security disability benefits and SSI payments based on disability. We considered the public comments we received on the interim final rule and, on March 3, 2008, issued the rule without change as a final rule. 73 FR 11349. Under this rule, attorney advisors may develop claims and, in appropriate cases, issue fully favorable decisions.

We included in the interim final rule a provision that the program would end on August 10, 2009, unless we decided to either terminate the rule earlier or to extend it beyond that date. We explained that we would announce any such termination or extension by publishing a final rule. 72 FR 44763, 44764 (August 10, 2007).

Explanation of Changes

The number of requests for hearings has increased significantly in recent years, and we expect that trend to continue. While we are pursuing a number of initiatives to address this increase, it will take time to feel the full effects. The attorney advisor program is an important part of our ongoing efforts to decide cases efficiently, issue decisions timely, and reduce the number of claims pending at the hearing level. Accordingly, we have decided to extend the attorney advisor rule for two more years, until August 10, 2011. As before, we are reserving the authority to end the program earlier, or to extend it, by publishing a final rule in the **Federal Register**.

We are also making a minor editorial change to the language in this rule. We are changing the term ''wholly favorable'' to ''fully favorable'' in §§ 404.942 and 416.1442, for clarity and consistency.

Regulatory Procedures

Justification for Issuing Final Rule Without Notice and Comment

We follow the Administrative Procedure Act (APA) rulemaking procedures specified in 5 U.S.C. 553 when developing regulations. Section 702(a)(5) of the Social Security Act, 42 U.S.C. 902(a)(5). The APA provides exceptions to its notice and public comment procedures when an agency finds there is good cause for dispensing with such procedures because they are impracticable, unnecessary, or contrary to the public interest. We have determined that good cause exists for dispensing with the notice and public comment procedures for this rule. 5 U.S.C. 553(b)(B). Good cause exists because this final rule only extends the sunset date of an existing rule. It makes no substantive changes to the rule. The current regulations expressly provide that we may extend or terminate this rule. Therefore, we have determined that opportunity for prior comment is unnecessary, and we are issuing this rule as a final rule.

In addition, because we are not making any substantive changes to an existing rule, there is good cause for dispensing with the 30-day delay in the effective date of a substantive rule provided by 5 U.S.C. 553(d)(3). To ensure that we have uninterrupted authority to use attorney advisors to reduce the number of pending cases at the hearing level, it is in the public interest to make this final rule effective on the date of publication.

Executive Order 12866

We have consulted with the Office of Management and Budget (OMB) and determined that this final rule does not meet the criteria for a significant regulatory action under Executive Order 12866 and was not subject to OMB formal review.

Regulatory Flexibility Act

We certify that this final rule will not have a significant economic impact on a substantial number of small entities as it affects only persons. Therefore, a regulatory flexibility analysis is not required under the Regulatory Flexibility Act, as amended.

Paperwork Reduction Act

This final rule contains reporting requirements in the regulation sections listed below. However, because there are fewer than ten respondents for each section, the Paperwork Reduction Act of 1995 does not require us to seek OMB clearance for these sections.

Regulation section	Description of public reporting requirement	Number of respondents (annually)	Frequency of response	Average burden per response (minutes)	Estimated annual burden
404.942(a), 416.1442(a).	If prehearing proceedings are not complete before the date of a hearing, an administrative law judge (ALJ) will receive the case unless a fully favorable decision is in process or all of the parties in the hearing agree in writing to delay the hearing until the proceedings are completed.	Less than 10 (PRA exempt).	.....	.....	.....
404.942(d), 416.1442(d).	If the attorney advisor issues a fully favorable decision under this section, we will mail a written notice of the decision to all parties at their last known address. We will state the basis for the decision and advise all parties that an ALJ will dismiss the hearing request unless a party requests that the hearing proceed. Parties who want to proceed with the hearing must request in writing within 30 days after the notice of the attorney advisor's decision is mailed.	Less than 10 (PRA-exempt).	.....	.....	.....
Totals		N/A	.....	.....	N/A

(Catalog of Federal Domestic Assistance Program Nos. 96.001, Social Security—Disability Insurance; 96.002, Social Security—Retirement Insurance; 96.004, Social Security—Survivors Insurance; 96.006, Supplemental Security Income.)

List of Subjects

20 CFR Part 404

Administrative practice and procedure; Blind, Disability benefits; Old-age, survivors, and disability insurance; Reporting and recordkeeping requirements; Social Security.

20 CFR Part 416

Administrative practice and procedure; Aged, blind, disability benefits, public assistance programs, Reporting and recordkeeping requirements; Supplemental Security Income (SSI).

Dated: July 7, 2009.

Michael J. Astrue,

Commissioner of Social Security.

■ For the reasons stated in the preamble, we are amending subpart J of part 404 and subpart N of part 416 of chapter III of title 20 of the Code of Federal Regulations as set forth below:

PART 404—FEDERAL OLD-AGE, SURVIVORS AND DISABILITY INSURANCE

(1950–)

Subpart J—[Amended]

■ 1. The authority citation for subpart J of part 404 continues to read as follows:

Authority: Secs. 201(j), 204(f), 205(a), (b), (d)–(h), and (j), 221, 223(i), 225, and 702(a)(5) of the Social Security Act (42 U.S.C. 401(j), 404(f), 405(a), (b), (d)–(h), and (j), 421, 423(i), 425, and 902(a)(5)); sec. 5, Public Law 97–455, 96 Stat. 2500 (42 U.S.C. 405 note); secs. 5, 6(c)–(e), and 15, Public Law 98–460, 98 Stat. 1802 (42 U.S.C. 421 note); sec. 202, Public Law 108–203, 118 Stat. 509 (42 U.S.C. 902 note).

■ 2. In § 404.942, amend the second and fourth sentences of paragraph (a), paragraphs (b)(4) and (c)(2), and the first sentence of paragraph (d) by removing the words ''wholly favorable'' and adding in their place the words ''fully favorable,'' and revise paragraph (g) to read as follows:

§ 404.942 Prehearing proceedings and decisions by attorney advisors.

* * * * *

(g) *Sunset provision.* The provisions of this section will no longer be effective on August 10, 2011, unless we terminate them earlier or extend them beyond that date by notice of a final rule in the **Federal Register**.

PART 416—SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED

Subpart N—[Amended]

■ 3. The authority citation for subpart N continues to read as follows:

Authority: Secs. 702(a)(5), 1631, and 1633 of the Social Security Act (42 U.S.C. 902(a)(5), 1383, and 1383b); sec. 202, Public Law 108–203, 118 Stat. 509 (42 U.S.C. 902 note).

■ 4. In § 416.1442, amend the second and fourth sentences of paragraph (a), paragraphs (b)(4) and (c)(2), and the first sentence of paragraph (d) by removing the words ''wholly favorable'' and adding in their place the words ''fully favorable,'' and revise paragraph (g) to read as follows:

§ 416.1442 Prehearing proceedings and decisions by attorney advisors.

* * * * *

(g) *Sunset provision.* The provisions of this section will no longer be effective on August 10, 2011, unless we terminate them earlier or extend them beyond that date by notice of a final rule in the **Federal Register**.

[FR Doc. E9–16510 Filed 7–10–09; 8:45 am]

BILLING CODE 4191–02–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 117

[USCG–09–0210]

Drawbridge Operation Regulations; Hackensack River, Jersey City, NJ, Maintenance

AGENCY: Coast Guard, DHS.

ACTION: Notice cancelling temporary deviation from regulations.

SUMMARY: The Coast Guard is cancelling the temporary deviation concerning the operation of the Witt Penn Bridge across the Hackensack River at mile 3.1, across the Hackensack River, at Jersey City, New Jersey. A temporary deviation was previously approved for the Lower Hack

Bridge at mile 3.4 across the Hackensack River and notice of that temporary deviation was made along with the notice for the Witt Penn Bridge. This temporary deviation was issued to facilitate bridge maintenance for the above bridges; however, the maintenance for the Witt Penn Bridge has been postponed necessitating the early cancellation of that portion of the temporary deviation. The maintenance of the Lower Hack Bridge will continue as planned, and the temporary deviation approved for the Lower Hack Bridge remains in effect. Once new dates are provided for the maintenance of the Witt Penn Bridge any new temporary deviation will be published in the **Federal Register**.

DATES: The temporary deviation published on April 29, 2009 (74 FR 19421) pertaining to the Witt Penn Bridge across the Hackensack River at mile 3.1, across the Hackensack River, at Jersey City, New Jersey is cancelled as of June 23, 2009.

ADDRESSES: The docket for this cancelled deviation is available for inspection or copying at the Docket Management Facility (M–30), U.S. Department of Transportation, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue, SE., Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. You may also find this docket on the Internet by going to *http://www.regulations.gov,* selecting the Advanced Docket Search option on the right side of the screen, inserting USCG–2009–0210 in the Docket ID box, pressing Enter, and then clicking on the item in the Docket ID column.

FOR FURTHER INFORMATION CONTACT: Gary Kassof, Project Officer, First Coast Guard District, *gary.kassof@uscg.mil,* telephone 212–668–7165.

SUPPLEMENTARY INFORMATION:

Background and Purpose

On April 29, 2009, we published a temporary deviation entitled ''Drawbridge Operation Regulations; New Jersey'' in the **Federal Register** (71 FR 19421). The temporary deviation concerned the Witt Penn Bridge at mile 3.1, and the Lower Hack Bridge, mile 3.4, both across the Hackensack River at Jersey City, New Jersey.

Cancellation

The Coast Guard received an additional request from the bridge owner of the Witt Penn Bridge, New Jersey Department of Transportation, on June 10, 2009, requesting the cancellation of the temporary deviation for the Witt Penn Bridge because the scheduled maintenance repairs did not begin on schedule due to a contractual dispute.

The work for the Lower Hack Bridge began on schedule and will continue through July 22, 2009, as planned.

The remaining bridge closure time period necessary to complete the maintenance work for the Lower Hack Bridge remains in effect through July 22, 2009. If granted, a temporary deviation for the Witt Penn Bridge covering the revised maintenance work period will be published under a new temporary deviation in the **Federal Register**.

The need to cancel the temporary deviation for the scheduled maintenance at the Witt Penn Bridge was due to a contractual dispute which delayed the start date of the bridge maintenance.

Dated: June 17, 2009.

Gary Kassof,

Bridge Program Manager, First Coast Guard District.

[FR Doc. E9–16397 Filed 7–10–09; 8:45 am]

BILLING CODE 4910–15–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA–R03–OAR–2009–0352; FRL–8929–2]

Approval and Promulgation of Air Quality Implementation Plans; Pennsylvania; Allegheny County, Continuous Opacity Monitor Regulation

AGENCY: Environmental Protection Agency (EPA).

ACTION: Direct final rule.

SUMMARY: EPA is taking direct final action to approve revisions to the Pennsylvania State Implementation Plan (SIP). This SIP revision, ''Revision 58, Continuous Opacity Monitor Regulation Changes,'' consists of changes to the Allegheny County Health Department (ACHD) Rules and Regulations, Article XXI, Air Pollution Control. EPA is approving this revision to the Pennsylvania SIP in accordance with the requirements of the Clean Air Act (CAA).

DATES: This rule is effective on September 11, 2009 without further notice, unless EPA receives adverse written comment by August 12, 2009. If EPA receives such comments, it will publish a timely withdrawal of the direct final rule in the **Federal Register** and inform the public that the rule will not take effect.

ADDRESSES: Submit your comments, identified by Docket ID Number EPA–R03–OAR–2009–0352 by one of the following methods:

A. *http://www.regulations.gov.* Follow the on-line instructions for submitting comments.

B. *E-mail: fernandez.cristina@epa.gov.*

C. *Mail:* EPA–R03–OAR–2009–0352, Cristina Fernandez, Chief, Air Quality Planning Branch, Mailcode 3AP21, U.S. Environmental Protection Agency, Region III, 1650 Arch Street, Philadelphia, Pennsylvania 19103.

D. *Hand Delivery:* At the previously listed EPA Region III address. Such deliveries are only accepted during the Docket's normal hours of operation, and special arrangements should be made for deliveries of boxed information.

Instructions: Direct your comments to Docket ID No. EPA–R03–OAR–2009–0352. EPA's policy is that all comments received will be included in the public docket without change, and may be made available online at *http://www.regulations.gov,* including any personal information provided, unless the comment includes information claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Do not submit information that you consider to be CBI or otherwise protected through *http://www.regulations.gov* or e-mail. The *http://www.regulations.gov* Web site is an ''anonymous access'' system, which means EPA will not know your identity or contact information unless you provide it in the body of your comment. If you send an e-mail comment directly to EPA without going through *http://www.regulations.gov,* your e-mail address will be automatically captured and included as part of the comment that is placed in the public docket and made available on the Internet. If you submit an electronic comment, EPA recommends that you include your name and other contact information in the body of your comment and with any disk or CD–ROM you submit. If EPA cannot read your comment due to technical difficulties and cannot contact you for clarification, EPA may not be able to consider your comment. Electronic files should avoid the use of special characters, any form of encryption, and be free of any defects or viruses.

Docket: All documents in the electronic docket are listed in the *http://www.regulations.gov* index. Although listed in the index, some information is not publicly available, *i.e.,* CBI or other information whose disclosure is restricted by statute.

Certain other material, such as copyrighted material, is not placed on the Internet and will be publicly available only in hard copy form. Publicly available docket materials are available either electronically in *http://www.regulations.gov* or in hard copy during normal business hours at the Air Protection Division, U.S. Environmental Protection Agency, Region III, 1650 Arch Street, Philadelphia, Pennsylvania 19103. Copies of the State submittal are available at the Allegheny County Health Department, Bureau of Environmental Quality, Division of Air Quality, 301 39th Street, Pittsburgh, Pennsylvania 15201.

FOR FURTHER INFORMATION CONTACT: Maria A. Pino, (215) 814–2181, or by e-mail at *pino.maria@epa.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

On May 16, 2007, the Commonwealth of Pennsylvania submitted a formal revision to the Pennsylvania SIP. The SIP revision consists of changes to Article XXI of the ACHD Rules and Regulations to specify the method to determine compliance with opacity requirements for coke oven combustion stacks, allow the use of continuous opacity monitoring systems (COMS) to measure visual emissions, and remove a redundant phrase in the current approved SIP.

II. Summary of SIP Revision

The revisions in ''Revision 58, Continuous Opacity Monitor Regulation Changes'' make three changes to the ACHD Rules and Regulations, Article XXI, Air Pollution Control.

The revision to § 2105.21.f specifies the method to determine compliance with opacity requirements for coke oven combustion stacks. The new language states that opacity measurements are to be performed according to the methods established in § 2107.11. This addition to § 2105.21.f strengthens the Pennsylvania SIP because the current SIP does not specify visible emission compliance methods for coke oven combustion stacks.

The revision to § 2107.11 allows the use of COMS to measure visual emissions. Previously, compliance with visible emission requirements was determined only by EPA Method 9, which requires a certified smoke reader to observe the emissions leaving the stack during daylight hours. EPA Method 9 had been the only federally acceptable method to determine compliance with visibility emissions. However, on February 24, 1997, EPA promulgated its Credible Evidence Revisions, which clarified that non-reference test data, i.e., any creditable evidence, can be used in enforcement actions and for compliance determinations under the Clean Air Act (62 FR 8314). Thus, Method 9 is not the exclusive means to determining compliance with visibility requirements, and the use of data from COMS is deemed acceptable. This change strengthens the Pennsylvania SIP by allowing the use of COMS data to determine compliance with visibility requirements, which will make compliance determinations easier.

The revision to § 2108.03 removes the redundant phrase, ''within the time specified,'' in the current approved SIP. This revision does not change the meaning of § 2108.03, but adds clarity. Therefore, this revision is approvable.

III. Final Action

EPA is approving ''Revision 58, Continuous Opacity Monitor Regulation Changes,'' submitted by the Commonwealth of Pennsylvania on May 16, 2007. The revision to § 2105.21.f specifies the method to determine compliance with opacity requirements for coke oven combustion stacks in Allegheny County. The revision to § 2107.11 allows the use of COMS to measure visual emissions in Allegheny County. The revision to § 2108.03 removes a redundant phrase in the current approved SIP. EPA is approving these revisions to the Pennsylvania SIP in accordance with the requirements of the CAA.

EPA is publishing this rule without prior proposal because the Agency views this as a noncontroversial amendment and anticipates no adverse comment. This revision to the Pennsylvania SIP serves to strengthen and add clarity to the SIP, but does not add any new regulatory requirements. However, in the ''Proposed Rules'' section of today's **Federal Register**, EPA is publishing a separate document that will serve as the proposal to approve the SIP revision if adverse comments are filed. This rule will be effective on September 11, 2009 without further notice unless EPA receives adverse comment by August 12, 2009. If EPA receives adverse comment, EPA will publish a timely withdrawal in the **Federal Register** informing the public that the rule will not take effect. EPA will address all public comments in a subsequent final rule based on the proposed rule. EPA will not institute a second comment period on this action. Any parties interested in commenting must do so at this time. Please note that if EPA receives adverse comment on an amendment, paragraph, or section of this rule and if that provision may be severed from the remainder of the rule, EPA may adopt as final those provisions of the rule that are not the subject of an adverse comment.

IV. Statutory and Executive Order Reviews

A. General Requirements

Under the Clean Air Act, the Administrator is required to approve a SIP submission that complies with the provisions of the Act and applicable Federal regulations. 42 U.S.C. 7410(k); 40 CFR 52.02(a). Thus, in reviewing SIP submissions, EPA's role is to approve state choices, provided that they meet the criteria of the Clean Air Act. Accordingly, this action merely approves state law as meeting Federal requirements and does not impose additional requirements beyond those imposed by state law. For that reason, this action:

- Is not a ''significant regulatory action'' subject to review by the Office of Management and Budget under Executive Order 12866 (58 FR 51735, October 4, 1993);
- Does not impose an information collection burden under the provisions of the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*);
- Is certified as not having a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*);
- Does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4);
- Does not have Federalism implications as specified in Executive Order 13132 (64 FR 43255, August 10, 1999);
- Is not an economically significant regulatory action based on health or safety risks subject to Executive Order 13045 (62 FR 19885, April 23, 1997);
- Is not a significant regulatory action subject to Executive Order 13211 (66 FR 28355, May 22, 2001);
- Is not subject to requirements of Section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) because application of those requirements would be inconsistent with the Clean Air Act; and
- Does not provide EPA with the discretionary authority to address, as appropriate, disproportionate human health or environmental effects, using practicable and legally permissible methods, under Executive Order 12898 (59 FR 7629, February 16, 1994).

In addition, this rule does not have tribal implications as specified by Executive Order 13175 (65 FR 67249, November 9, 2000), because the SIP is not approved to apply in Indian country located in the State, and EPA notes that it will not impose substantial direct costs on tribal governments or preempt tribal law.

B. Submission to Congress and the Comptroller General

The Congressional Review Act, 5 U.S.C. 801 *et seq.,* as added by the Small Business Regulatory Enforcement Fairness Act of 1996, generally provides that before a rule may take effect, the agency promulgating the rule must submit a rule report, which includes a copy of the rule, to each House of the Congress and to the Comptroller General of the United States. EPA will submit a report containing this action and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the rule in the **Federal Register**. A major rule cannot take effect until 60 days after it is published in the **Federal Register**. This action is not a ''major rule'' as defined by 5 U.S.C. 804(2).

C. Petitions for Judicial Review

Under section 307(b)(1) of the Clean Air Act, petitions for judicial review of this action must be filed in the United States Court of Appeals for the appropriate circuit by September 11, 2009. Filing a petition for reconsideration by the Administrator of this final rule does not affect the finality of this action for the purposes of judicial review nor does it extend the time within which a petition for judicial review may be filed, and shall not postpone the effectiveness of such rule or action. Parties with objections to this direct final rule are encouraged to file a comment in response to the parallel notice of proposed rulemaking for this action published in the proposed rules section of today's **Federal Register**, rather than file an immediate petition for judicial review of this direct final rule, so that EPA can withdraw this direct final rule and address the comment in the proposed rulemaking.

This action, which revises the Pennsylvania SIP to establish the method to determine compliance with opacity requirements for coke oven combustion stacks and allows the use of COMS to measure visible emissions in Allegheny County, and removes a redundant phrase in the current approved SIP, may not be challenged later in proceedings to enforce its requirements. (See section 307(b)(2).)

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Incorporation by reference, Nitrogen dioxide, Particulate matter, Reporting and recordkeeping requirements, Sulfur oxides.

Dated: July 1, 2009.

William C. Early,

Acting Regional Administrator, Region III.

■ 40 CFR part 52 is amended as follows:

PART 52—[AMENDED]

■ 1. The authority citation for part 52 continues to read as follows:

Authority: 42 U.S.C. 7401 *et seq.*

Subpart NN—Pennsylvania

■ 2. In § 52.2020, the table in paragraph (c)(2) is amended by revising the entries for Article XXI, Sections 2105.21, 2107.11, and 2108.03 to read as follows:

§ 52.2020 Identification of plan.

* * * * *

(c) * * *

(2) * * *

Article XX or XXI citation	Title/subject	State effective date	EPA approval date	Additional explanation/§ 52.2063 citation
*	*	*	*	*
Part E—Source Emission and Operating Standards				
*	*	*	*	*
Subpart 2—Slag, Coke, and Miscellaneous Sulfur Sources				
*	*	*	*	*
§ 2105.21	Coke Oven and Coke Gas Oven.	4/1/07	7/13/09, [Insert page number where the document begins].	Revision to paragraph 2105.21.f (Combustion Stacks).
*	*	*	*	*
Part G—Methods				
*	*	*	*	*
§ 2107.11	Visible Emissions	4/1/07	7/13/09, [Insert page number where the document begins].	
*	*	*	*	*
Part H—Reporting, Testing & Monitoring				
*	*	*	*	*
§ 2108.03	Continuous Emission Monitoring.	4/1/07	7/13/09, [Insert page number where the document begins].	Revision to paragraph 2108.03.f (Violations).
*	*	*	*	*

* * * * *

[FR Doc. E9–16365 Filed 7–10–09; 8:45 am]
BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[VA201–5202; FRL–8923–9]

Approval and Promulgation of Air Quality Implementation Plans; Virginia; Update to Materials Incorporated by Reference

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule; administrative change.

SUMMARY: EPA is updating the materials submitted by Virginia that are incorporated by reference (IBR) into the State implementation plan (SIP). The regulations affected by this update have been previously submitted by the Virginia Department of Environmental Quality (DEQ) and approved by EPA. This update affects the SIP materials that are available for public inspection at the National Archives and Records Administration (NARA), the Air and Radiation Docket and Information Center located at EPA Headquarters in Washington, DC, and the Regional Office.

DATES: *Effective Date:* This action is effective July 13, 2009.

ADDRESSES: SIP materials which are incorporated by reference into 40 CFR part 52 are available for inspection at the following locations: Air Protection Division, U.S. Environmental Protection Agency, Region III, 1650 Arch Street, Philadelphia, Pennsylvania 19103; the Air and Radiation Docket and Information Center, EPA Headquarters Library, Room Number 3334, EPA West Building, 1301 Constitution Ave. NW., Washington, DC 20460, and the National Archives and Records Administration. If you wish to obtain materials from a docket in the EPA Headquarters Library, please call the Office of Air and Radiation (OAR) Docket/Telephone number: (202) 566–1742; or the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.*

FOR FURTHER INFORMATION CONTACT: Harold A. Frankford, (215) 814–2108 or by e-mail at *frankford.harold@epa.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

The SIP is a living document which the State revises as necessary to address the unique air pollution problems. Therefore, EPA from time to time must take action on SIP revisions containing new and/or revised regulations to make them part of the SIP. On May 22, 1997 (62 FR 27968), EPA revised the procedures for incorporating by reference Federally-approved SIPs, as a result of consultations between EPA and the Office of the **Federal Register** (OFR). The description of the revised SIP document, IBR procedures and ''Identification of plan'' format are discussed in further detail in the May 22, 1997 **Federal Register** document. On April 21, 2000 (65 FR 21315), EPA published a **Federal Register** action beginning the new IBR procedure for Virginia. On September 8, 2004 (69 FR 54216), November 3, 2005 (70 FR 66769) and July 16, 2007 (72 FR 38920), EPA published updates to the IBR material for Virginia.

II. EPA Action

In this document, EPA is doing the following:

A. Announcing the update to the IBR material as of June 1, 2009.

B. Making corrections to the following entries listed in the paragraph 52.2420(c) table, as described below:

1. In the entry 5–20–203, revising the text in the ''Title/subject'' column.

2. Revising the titles for the following entries: Chapter 40, Part II, Articles 49 and 50.

3. Incorporating the entry for 5–40–1750.

4. In the entry 5–40–1670, reorganizing the text in the ''Title/subject'' and ''Explanation [former SIP citation]'' columns without making any substantive revisions to the list of SIP-approved definitions.

5. In the entry 5–40–5610, removing the quotation marks from the terms listed in the ''Explanation [former SIP section]'' column.

6. In the entry 5–40–7810, removing the quotation marks from the terms listed in the ''Title/subject'' column.

7. Removing entries 5–80–1835, 5–80–1845, and 5–80–1855, they are designated as ''reserved,'' and contain no text that is incorporated by reference.

8. In the entry 5–80–2130, correcting a typographical error to the text in the ''Title/subject'' column.

9. Correcting the date format in the ''State effective date'' column for the following entries: Chapter 10, section 5–10–20; Chapter 20, section 5–20–203; Chapter 40, Part II, Article 4, section 5–40–300; Article 36, section 5–40–5060; Article 37, section 5–40–5200; Article 41, section 5–40–5700; Article 42, sections 5–40–5700, 5–40–5720, and 5–20–5750; Article 48, section 5–40–6970; Article 49, sections 5–40–7120, 5–40–7130, 5–40–7140, and 5–40–7210; Article 50, sections 5–40–7240, 5–40–7270, 5–40–7300, 5–40–7330, and 5–40–7360; Article 53, all sections; and Chapter 230, all sections.

C. In the paragraph 52.2420(d) table, correcting the date format in the ''State effective date'' column for the following entries: Columbia Gas Transmission Company-Loudoun County Compressor Station, and Global Stone Chemstone Corporation.

D. Making corrections to the following entries listed in the paragraph 52.2420(e) table, as described below:

1. Rearranging the order of entries for ''Documents Incorporated by Reference.''

2. Correcting the date format in the ''State effective date'' column for the following entries: All nonregulatory and quasi-regulatory entries associated with the Washington 1-hour ozone nonattainment area, and the entry for RACT under the 8-Hour NAAQS (Stafford County).

3. Removing the SIP effective date text in the ''Additional explanation column'' for the entry entitled ''Documents Incorporated by Reference (9 VAC 5–20–21, Paragraphs E.4.a.(21) and (22)).'' EPA has determined that today's rule falls under the ''good cause'' exemption in section 553(b)(3)(B) of the Administrative Procedures Act (APA) which, upon finding ''good cause,'' authorizes agencies to dispense with public participation, and section 553(d)(3) which allows an agency to make a rule effective immediately (thereby avoiding the 30-day delayed effective date otherwise provided for in the APA). Today's rule simply codifies provisions which are already in effect as a matter of law in Federal and approved State programs. Under section 553 of the APA, an agency may find good cause where procedures are ''impractical, unnecessary, or contrary to the public interest.'' Public comment is ''unnecessary'' and ''contrary to the public interest'' since the codification only reflects existing law. Immediate notice in the CFR benefits the public by removing outdated citations and incorrect chart entries.

III. Statutory and Executive Order Reviews

A. General Requirements

Under the Clean Air Act, the Administrator is required to approve a SIP submission that complies with the

provisions of the Act and applicable Federal regulations. 42 U.S.C. 7410(k); 40 CFR 52.02(a). Thus, in reviewing SIP submissions, EPA's role is to approve state choices, provided that they meet the criteria of the Clean Air Act. Accordingly, this action merely approves state law as meeting Federal requirements and does not impose additional requirements beyond those imposed by state law. For that reason, this action:

• Is not a ''significant regulatory action'' subject to review by the Office of Management and Budget under Executive Order 12866 (58 FR 51735, October 4, 1993);

• Does not impose an information collection burden under the provisions of the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*);

• Is certified as not having a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*);

• Does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4);

• Does not have Federalism implications as specified in Executive Order 13132 (64 FR 43255, August 10, 1999);

• Is not an economically significant regulatory action based on health or safety risks subject to Executive Order 13045 (62 FR 19885, April 23, 1997);

• Is not a significant regulatory action subject to Executive Order 13211 (66 FR 28355, May 22, 2001);

• Is not subject to requirements of Section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) because application of those requirements would be inconsistent with the Clean Air Act; and

• Does not provide EPA with the discretionary authority to address, as appropriate, disproportionate human health or environmental effects, using practicable and legally permissible methods, under Executive Order 12898 (59 FR 7629, February 16, 1994).

B. Submission to Congress and the Comptroller General

The Congressional Review Act, 5 U.S.C. 801 *et seq.,* as added by the Small Business Regulatory Enforcement Fairness Act of 1996, generally provides that before a rule may take effect, the agency promulgating the rule must submit a rule report, which includes a copy of the rule, to each House of the Congress and to the Comptroller General of the United States. EPA will submit a report containing this rule and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the rule in the **Federal Register**. This rule is not a ''major rule'' as defined by 5 U.S.C. 804(2).

C. Petitions for Judicial Review

EPA has also determined that the provisions of section 307(b)(1) of the Clean Air Act pertaining to petitions for judicial review are not applicable to this action. Prior EPA rulemaking actions for each individual component of the Virginia SIP compilations had previously afforded interested parties the opportunity to file a petition for judicial review in the United States Court of Appeals for the appropriate circuit within 60 days of such rulemaking action. Thus, EPA sees no need in this action to reopen the 60-day period for filing such petitions for judicial review for this ''Identification of plan'' reorganization update action for Virginia.

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Carbon monoxide, Incorporation by reference, Intergovernmental relations, Lead, Nitrogen dioxide, Ozone, Particulate matter, Reporting and recordkeeping requirements, Sulfur oxides, Volatile organic compounds.

Dated: June 11, 2009.

William C. Early,

Acting Regional Administrator, Region III.

■ 40 CFR part 52 is amended as follows:

PART 52—[AMENDED]

■ 1. The authority for citation for part 52 continues to read as follows:

Authority: 42.U.S.C. 7401 *et seq.*

Subpart VV—Virginia

■ 2. Section 52.2420 is amended by revising paragraphs (b), (c), (d), and (e) to read as follows:

§ 52.2420 Identification of plan.

* * * * *

(b) Incorporation by reference.

(1) Material listed as incorporated by reference in paragraphs (c) and (d) was approved for incorporation by reference by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. Material incorporated as it exists on the date of the approval, and notice of any change in the material will be published in the **Federal Register**. Entries in paragraphs (c) and (d) of this section with EPA approval dates on or after June 1, 2009 will be incorporated by reference in the next update to the SIP compilation.

(2) EPA Region III certifies that the rules/regulations and source-specific requirements provided by EPA at the addresses in paragraph (b)(3) of this section are an exact duplicate of the officially promulgated State rules/regulations and source-specific requirements which have been approved as part of the State implementation plan as of June 1, 2009.

(3) Copies of the materials incorporated by reference may be inspected at the EPA Region III Office at 1650 Arch Street, Philadelphia, PA 19103. For further information, call (215) 814–2108; the EPA, Air and Radiation Docket and Information Center, Room Number 3334, EPA West Building, 1301 Constitution Avenue NW., Washington, DC. 20460. For further information, call (202) 566–1742; or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: *http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.*

(c) EPA-approved regulations.

EPA-APPROVED VIRGINIA REGULATIONS AND STATUTES

State citation	Title/subject	State effective date	EPA approval date	Explanation [former SIP citation]
9 VAC 5, Chapter 10 General Definitions [Part I]				
5–10–10	General	8/1/02	3/15/04, 69 FR 12074	Revised paragraphs A, B, C.

EPA-APPROVED VIRGINIA REGULATIONS AND STATUTES—Continued

State citation	Title/subject	State effective date	EPA approval date	Explanation [former SIP citation]
5–10–20	Terms Defined—Definitions of Administrator, Federally Enforceable, Implementation Plan, Potential to Emit, State Enforceable, Volatile Organic Compound.	4/1/96	3/12/97, 62 FR 11334	§ 52.2465(c)(113)(i)(B)(1).
5–10–20	Terms Defined—Added Terms—Department, Virginia Register Act, Revised Terms—Administrative Process Act, Director (replaces Executive Director), Virginia Air Pollution Control Law.	4/17/95	4/21/00, 65 FR 21315.	
5–10–20	Terms Defined [all other SIP-approved terms not listed above].	4/17/95	4/21/00, 65 FR 21315	120–01–02.
5–10–20	Terms Defined	1/1/98	1/7/03, 68 FR 663	Terms Added—Public hearing; Regulations for the Control and Abatement of Air Pollution, Regulation of the Board, These regulations. Terms Revised—Good Engineering Practice, Person, Volatile organic compound. Terms Deleted (moved to 9 VAC 5–170–20)—Administrative Process Act, Air quality maintenance area, Confidential information, Consent agreement, Consent order, Emergency special order, Order, Special order, Variance.
5–10–20	Terms Defined	8/1/02	3/15/04, 69 FR 12074	Terms Added: EPA, Initial emissions test, Initial performance test (as corrected 11/05/03 and effective 01/01/04 in the Commonwealth), Maintenance area. Terms Revised: Affected facility, Delayed compliance order, Excessive concentration, Federally enforceable, Malfunction, Public hearing, Reference method, Reid vapor pressure, Stationary source, True vapor pressure, Vapor pressure, Volatile organic compounds. Terms Removed: Air Quality Maintenance Area.
5–10–20	Terms Defined	5/04/05	8/18/06, 71 FR 47742	Definition of "volatile organic compound".
5–10–30	Abbreviations	7/1/97	4/21/00, 65 FR 21315	Appendix A.
	9 VAC 5, Chapter 20 General Provisions			
	Part I Administrative			
5–20–10A.–C	Applicability	4/17/95	4/21/00, 65 FR 21315	120–02–01.
5–20–70	Circumvention	4/17/95	4/21/00, 65 FR 21315	120–02–07.
5–20–80	Relationship of state regulations to Federal regulations.	4/17/95	4/21/00, 65 FR 21315	120–02–08.
5–20–121	Air Quality Program Policies and Procedures.	7/1/97	4/21/00, 65 FR 21315	Appendix S.
	Part II Air Quality Programs			
5–20–160	Registration	4/17/95	4/21/00, 65 FR 21315	120–02–31.
5–20–170	Control Programs	4/17/95	4/21/00, 65 FR 21315	120–02–32.
5–20–180	Facility and Control Equipment Maintenance or Malfunction.	4/17/95	4/21/00, 65 FR 21315	120–02–34.
5–20–200	Air Quality Control Regions (AQCR)	7/1/97	4/21/00, 65 FR 21315	Appendix B.
5–20–202	Metropolitan Statistical Areas	7/1/97	4/21/00, 65 FR 21315	Appendix G.
5–20–203	Air Quality Maintenance Areas	7/29/08	10/29/08, 73 FR 64210	Richmond and Hampton Roads 8-Hour Ozone Areas are added.
5–20–204	Nonattainment Areas	7/29/08	10/29/08, 73 FR 64210	Richmond and Hampton Roads 8-Hour Ozone Areas are deleted.

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State citation	Title/subject	State effective date	EPA approval date	Explanation [former SIP citation]
5–20–205	Prevention of Significant Deterioration Areas.	01/01/98, 04/01/98, 01/01/99, 08/25/04	8/18/06, 71 FR 47744.	
5–20–206	Volatile Organic Compound and Nitrogen Oxides Emissions Control Areas.	10/04/06	3/2/07, 72 FR 9441	Addition of new Fredericksburg Area and expansion of Richmond and Hampton Roads Emission Control Areas.
5–20–220	Shutdown of a stationary source	4/1/98	6/27/03, 68 FR 38191.	
5–20–230	Certification of Documents	4/1/98	6/27/03, 68 FR 38191.	
VR120, Part II General Provisions				
VR120–02–02	Establishment of Regulations and Orders.	2/1/85	2/25/93, 58 FR 11373	EPA has informed VA that except for the Appeals rule, these provisions no longer need to be part of the SIP. VA has withdrawn 2/93 and 2/98 revisions to the Appeals rule from SIP review. Last substantive SIP change became State-effective on 8/6/79 [§ 52.2465(c)(55)].
VR120–02–04	Hearings and Proceedings	2/1/85	2/25/93, 58 FR 11373.	
VR120–02–05A	Variances—General	2/1/85	2/25/93, 58 FR 11373.	
VR 2.05(b)	Variances—Fuel Emergency	8/14/75	10/8/80, 45 FR 66792.	
VR120–02–09	Appeals	2/1/85	2/25/93, 58 FR 11373.	
VR120–02–12	Procedural information and guidance	2/1/85	2/25/93, 58 FR 11373.	
Appendix E	Public Participation Guidelines	2/1/85	2/25/93, 58 FR 11373.	
Appendix F	Delegation of Authority	2/1/85	2/25/93, 58 FR 11373.	
9 VAC 5, Chapter 30 Ambient Air Quality Standards [Part III]				
5–30–10	General	9/8/04	3/3/06, 71 FR 10842.	
5–30–30	Sulfur Oxides (Sulfur Dioxide)	9/8/04	3/3/06, 71 FR 10842.	
5–30–40	Carbon Monoxide	9/8/04	3/3/06, 71 FR 10842.	
5–30–50	Ozone (1-hour)	9/8/04	3/3/06, 71 FR 10842.	
5–30–55	Ozone (8-hour)	9/8/04	3/3/06, 71 FR 10842	Added Section.
5–30–60	Particulate Matter (PM10)	9/8/04	3/3/06, 71 FR 10842.	
5–30–65	Particulate Matter	9/8/04	3/3/06, 71 FR 10842	Added Section.
5–30–70	Nitrogen Dioxide	9/8/04	3/3/06, 71 FR 10842.	
5–30–80	Lead	9/8/04	3/3/06, 71 FR 10842.	
9 VAC 5, Chapter 40 Existing Stationary Sources [Part IV] Part I Special Provisions				
5–40–10	Applicability	8/1/02	3/15/04, 69 FR 12074.	
5–40–20 (except paragraph A.4.).	Compliance	8/1/02	3/15/04, 69 FR 12074.	
5–40–21	Compliance Schedules	7/1/97	4/21/00, 65 FR 21315	Appendix N.
5–40–22	Interpretation of Emissions Standards Based on Process Weight-Rate Tables.	7/1/97	4/21/00, 65 FR 21315	Appendix Q.
5–40–30	Emission Testing	8/1/02	3/15/04, 69 FR 12074.	
5–40–40	Monitoring	8/1/02	3/15/04, 69 FR 12074.	
5–40–41	Emission Monitoring Procedures for Existing Sources.	7/1/97	4/21/00, 65 FR 21315	Appendix J.
5–40–50	Notification, Records and Reporting	8/1/02	3/15/04, 69 FR 12074.	
Part II Emission Standards Article 1 Visible Emissions and Fugitive Dust/Emissions (Rule 4–1)				
5–40–60	Applicability and Designation of Affected Facility.	4/17/95	4/21/00, 65 FR 21315	120–04–0101.
5–40–70	Definitions	4/17/95	4/21/00, 65 FR 21315	120–04–0102.
5–40–80	Standard for Visible Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–0103.
5–40–90	Standard for Fugitive Dust/Emissions	2/1/03	4/29/05, 70 FR 22263.	
5–40–100	Monitoring	4/17/95	4/21/00, 65 FR 21315	120–04–0105.
5–40–110	Test Methods and Procedures	4/17/95	4/21/00, 65 FR 21315	120–04–0106.
5–40–120	Waivers	2/1/03	4/29/05, 70 FR 22263.	

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State citation	Title/subject	State effective date	EPA approval date	Explanation [former SIP citation]
Article 4 Emission Standards for General Process Operations (Rule 4–4)				
5–40–240	Applicability and Designation of Affected Facility.	1/2/02	2/28/08, 73 FR 10670.	
5–40–250	Definitions	1/2/02	2/28//08, 73 FR 10670.	
5–40–260	Standard for Particulate Matter(AQCR 1–6).	4/17/95	4/21/00, 65 FR 21315	120–04–0403.
5–40–270	Standard for Particulate Matter (AQCR 7).	4/17/95	4/21/00, 65 FR 21315	120–04–0404.
5–40–280	Standard for Sulfur Dioxide	4/17/95	4/21/00, 65 FR 21315	120–04–0405.
5–40–300	Standard for Volatile Organic Compounds.	10/4/06	3/2/07, 72 FR 9441.	
5–40–310A.–E	Standard for Nitrogen Oxides	3/24/04	4/27/05, 70 FR 21625.	
5–40–311	Reasonably available control technology guidelines for stationary sources of nitrogen dioxide.	1/2/02	2/28/08, 73 FR 10670	Removal of definitions Combustion unit, Fuel burning equipment Installation, and Total capacity in 9 VAC 5–40–311B.3. Exception: 311D.
5–40–320	Standard for Visible Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–0409.
5–40–330	Standard for Fugitive Dust/Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–0410.
5–40–360	Compliance	4/17/95	4/21/00, 65 FR 21315	120–04–0413.
5–40–370	Test Methods and Procedures	4/17/95	4/21/00, 65 FR 21315	120–04–0414.
5–40–380	Monitoring	4/17/95	4/21/00, 65 FR 21315	120–04–0415.
5–40–390	Notification, Records and Reporting	4/17/95	4/21/00, 65 FR 21315	120–04–0416.
5–40–400	Registration	4/17/95	4/21/00, 65 FR 21315	120–04–0417.
5–40–410	Facility and Control Equipment Maintenance or Malfunction.	4/17/95	4/21/00, 65 FR 21315	120–04–0418.
5–40–420	Permits	4/17/95	4/21/00, 65 FR 21315	120–04–0419.
Article 5 Emission Standards for Synthesized Pharmaceutical Products Manufacturing Operations (Rule 4–5)				
5–40–430	Applicability and Designation of Affected Facility.	4/17/95	4/21/00, 65 FR 21315	120–04–0501.
5–40–440	Definitions	4/17/95	4/21/00, 65 FR 21315	120–04–0502.
4–40–450	Standard for Volatile Organic Compounds.	4/17/95	4/21/00, 65 FR 21315	120–04–0503.
5–40–460	Control Technology Guidelines	2/1/02	3/3/06, 71 FR 10838.	
5–40–470	Standard for Visible Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–0505.
5–40–480	Standard for Fugitive Dust/Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–0506.
5–40–510	Compliance	4/17/95	4/21/00, 65 FR 21315	120–04–0509.
5–40–520	Test Methods and Procedures	4/17/95	4/21/00, 65 FR 21315	120–04–0510.
5–40–530	Monitoring	4/17/95	4/21/00, 65 FR 21315	120–04–0511.
5–40–540	Notification, Records and Reporting	4/17/95	4/21/00, 65 FR 21315	120–04–0512.
5–40–550	Registration	4/17/95	4/21/00, 65 FR 21315	120–04–0513.
5–40–560	Facility and Control Equipment Maintenance or Malfunction.	4/17/95	4/21/00, 65 FR 21315	120–04–0514.
5–40–570	Permits	4/17/95	4/21/00, 65 FR 21315	120–04–0515.
Article 6 Emission Standards for Rubber Tire Manufacturing Operations (Rule 4–6)				
5–40–580	Applicability and Designation of Affected Facility.	4/17/95	4/21/00, 65 FR 21315	120–04–0601.
5–40–590	Definitions	4/17/95	4/21/00, 65 FR 21315	120–04–0602.
5–40–600	Standard for Volatile Organic Compounds.	4/17/95	4/21/00, 65 FR 21315	120–04–0603.
5–40–610	Control Technology Guidelines	4/17/95	4/21/00, 65 FR 21315	120–04–0604.
5–40–620	Standard for Visible Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–0605.
5–40–630	Standard for Fugitive Dust/Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–0606.
5–40–660	Compliance	4/17/95	4/21/00, 65 FR 21315	120–04–0609.
5–40–670	Test Methods and Procedures	4/17/95	4/21/00, 65 FR 21315	120–04–0610.
5–40–680	Monitoring	4/17/95	4/21/00, 65 FR 21315	120–04–0611.
5–40–690	Notification, Records and Reporting	4/17/95	4/21/00, 65 FR 21315	120–04–0612.
5–40–700	Registration	4/17/95	4/21/00, 65 FR 21315	120–04–0613.
5–40–710	Facility and Control Equipment Maintenance or Malfunction.	4/17/95	4/21/00, 65 FR 21315	120–04–0614.
5–40–720	Permits	4/17/95	4/21/00, 65 FR 21315	120–04–0615.
Article 7 Emission Standards for Incinerators (Rule 4–7)				
5–40–730	Applicability and Designation of Affected Facility.	4/17/95	4/21/00, 65 FR 21315	120–04–0701.
5–40–740	Definitions	4/17/95	4/21/00, 65 FR 21315	120–04–0702.

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State citation	Title/subject	State effective date	EPA approval date	Explanation [former SIP citation]
5–40–750	Standard for Particulate Matter	4/17/95	4/21/00, 65 FR 21315	120–04–0703.
5–40–760	Standard for Visible Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–0704.
5–40–770	Standard for Fugitive Dust/Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–0705.
5–40–800	Prohibition of Flue-Fed Incinerators	4/17/95	4/21/00, 65 FR 21315	120–04–0708.
5–40–810	Compliance	4/17/95	4/21/00, 65 FR 21315	120–04–0709.
5–40–820	Test Methods and Procedures	4/17/95	4/21/00, 65 FR 21315	120–04–0710.
5–40–830	Monitoring	4/17/95	4/21/00, 65 FR 21315	120–04–0711.
5–40–840	Notification, Records and Reporting	4/17/95	4/21/00, 65 FR 21315	120–04–0712.
5–40–850	Registration	4/17/95	4/21/00, 65 FR 21315	120–04–0713.
5–40–860	Facility and Control Equipment Maintenance or Malfunction.	4/17/95	4/21/00, 65 FR 21315	120–04–0714.
5–40–870	Permits	4/17/95	4/21/00, 65 FR 21315	120–04–0715.
Article 8 Emission Standards for Fuel Burning Equipment (Rule 4–8)				
5–40–880	Applicability and Designation of Affected Facility.	4/1/99	5/31/01, 66 FR 29495.	
5–40–890	Definitions	4/1/99	5/31/01, 66 FR 29495.	
5–40–900	Standard for Particulate Matter	4/1/99	5/31/01, 66 FR 29495.	
5–40–910	Emission Allocation System	4/17/95	4/21/00, 65 FR 21315	120–04–0804.
5–40–920	Determination of Collection Equipment Efficiency Factor.	4/17/95	4/21/00, 65 FR 21315	120–04–0805.
5–40–930	Standard for Sulfur Dioxide	4/17/95	4/21/00, 65 FR 21315	120–04–0806.
5–40–940	Standard for Visible Emissions	4/1/99	5/31/01, 66 FR 29495.	
5–40–950	Standard for Fugitive Dust/Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–0808.
5–40–980	Compliance	4/17/95	4/21/00, 65 FR 21315	120–04–0811.
5–40–990	Test Methods and Procedures	4/17/95	4/21/00, 65 FR 21315	120–04–0812.
5–40–1000	Monitoring	4/17/95	4/21/00, 65 FR 21315	120–04–0813.
5–40–1010	Notification, Records and Reporting	4/17/95	4/21/00, 65 FR 21315	120–04–0814.
5–40–1020	Registration	4/17/95	4/21/00, 65 FR 21315	120–04–0815.
5–40–1030	Facility and Control Equipment Maintenance or Malfunction.	4/17/95	4/21/00, 65 FR 21315	120–04–0816.
5–40–1040	Permits	4/1/99	5/31/01, 66 FR 29495.	
Article 9 Emission Standards for Coke Ovens (Rule 4–9)				
5–40–1050	Applicability and Designation of Affected Facility.	4/17/95	4/21/00, 65 FR 21315	120–04–0901.
5–40–1060	Definitions	4/17/95	4/21/00, 65 FR 21315	120–04–0902.
5–40–1070	Standard for Particulate Matter	4/17/95	4/21/00, 65 FR 21315	120–04–0903.
5–40–1080	Standard for Sulfur Dioxide	4/17/95	4/21/00, 65 FR 21315	120–04–0904.
5–40–1090	Standard for Visible Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–0905.
5–40–1100	Standard for Fugitive Dust/Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–0906.
5–40–1130	Compliance	4/17/95	4/21/00, 65 FR 21315	120–04–0909.
5–40–1140	Test Methods and Procedures	4/17/95	4/21/00, 65 FR 21315	120–04–0910.
5–40–1150	Monitoring	4/17/95	4/21/00, 65 FR 21315	120–04–0911.
5–40–1160	Notification, Records and Reporting	4/17/95	4/21/00, 65 FR 21315	120–04–0912.
5–40–1170	Registration	4/17/95	4/21/00, 65 FR 21315	120–04–0913.
5–40–1180	Facility and Control Equipment Maintenance or Malfunction.	4/17/95	4/21/00, 65 FR 21315	120–04–0914.
5–40–1190	Permits	4/17/95	4/21/00, 65 FR 21315	120–04–0915.
Article 10 Emission Standards for Asphalt Concrete Plants (Rule 4–10)				
5–40–1200	Applicability and Designation of Affected Facility.	4/17/95	4/21/00, 65 FR 21315	120–04–1001.
5–40–1210	Definitions	4/17/95	4/21/00, 65 FR 21315	120–04–1002.
5–40–1220	Standard for Particulate Matter	4/17/95	4/21/00, 65 FR 21315	120–04–1003.
5–40–1230	Standard for Visible Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–1004.
5–40–1240	Standard for Fugitive Dust/Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–1005.
5–40–1270	Compliance	4/17/95	4/21/00, 65 FR 21315	120–04–1008.
5–40–1280	Test Methods and Procedures	4/17/95	4/21/00, 65 FR 21315	120–04–1009.
5–40–1290	Monitoring	4/17/95	4/21/00, 65 FR 21315	120–04–1010.
5–40–1300	Notification, Records and Reporting	4/17/95	4/21/00, 65 FR 21315	120–04–1011.
5–40–1310	Registration	4/17/95	4/21/00, 65 FR 21315	120–04–1012.
5–40–1320	Facility and Control Equipment Maintenance or Malfunction.	4/17/95	4/21/00, 65 FR 21315	120–04–1013.
5–40–1330	Permits	4/17/95	4/21/00, 65 FR 21315	120–04–1014.

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State citation	Title/subject	State effective date	EPA approval date	Explanation [former SIP citation]
Article 11 Emission Standards for Petroleum Refinery Operations (Rule 4–11)				
5–40–1340	Applicability and Designation of Affected Facility.	4/17/95	4/21/00, 65 FR 21315	120–04–1101.
5–40–1350	Definitions	4/17/95	4/21/00, 65 FR 21315	120–04–1102.
5–40–1360	Standard for Particulate Matter	4/17/95	4/21/00, 65 FR 21315	120–04–1103.
5–40–1370	Standard for Sulfur Dioxide	4/17/95	4/21/00, 65 FR 21315	120–04–1104.
5–40–1390	Standard for Volatile Organic Compounds.	4/17/95	4/21/00, 65 FR 21315	120–04–1106.
5–40–1400	Control Technology Guidelines	4/17/95	4/21/00, 65 FR 21315	120–04–1107.
5–40–1410	Standard for Visible Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–1108.
5–40–1420	Standard for Fugitive Dust/Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–1109.
5–40–1450	Compliance	4/17/95	4/21/00, 65 FR 21315	120–04–1112.
5–40–1460	Test Methods and Procedures	4/17/95	4/21/00, 65 FR 21315	120–04–1113.
5–40–1470	Monitoring	4/17/95	4/21/00, 65 FR 21315	120–04–1114.
5–40–1480	Notification, Records and Reporting	4/17/95	4/21/00, 65 FR 21315	120–04–1115.
5–40–1490	Registration	4/17/95	4/21/00, 65 FR 21315	120–04–1116.
5–40–1500	Facility and Control Equipment Maintenance or Malfunction.	4/17/95	4/21/00, 65 FR 21315	120–04–1117.
5–40–1510	Permits	4/17/95	4/21/00, 65 FR 21315	120–04–1118.
Article 12 Emission Standards for Chemical Fertilizer Manufacturing Operations (Rule 4–12)				
5–40–1520	Applicability and Designation of Affected Facility.	4/17/95	4/21/00, 65 FR 21315	120–04–1201.
5–40–1530	Definitions	4/17/95	4/21/00, 65 FR 21315	120–04–1202.
5–40–1540	Standard for Particulate Matter	4/17/95	4/21/00, 65 FR 21315	120–04–1203.
5–40–1550	Standard for Visible Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–1204.
5–40–1560	Standard for Fugitive Dust/Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–1205.
5–40–1590	Compliance	4/17/95	4/21/00, 65 FR 21315	120–04–1208.
5–40–1600	Test Methods and Procedures	4/17/95	4/21/00, 65 FR 21315	120–04–1209.
5–40–1610	Monitoring	4/17/95	4/21/00, 65 FR 21315	120–04–1210.
5–40–1620	Notification, Records and Reporting	4/17/95	4/21/00, 65 FR 21315	120–04–1211.
5–40–1630	Registration	4/17/95	4/21/00, 65 FR 21315	120–04–1212.
5–40–1640	Facility and Control Equipment Maintenance or Malfunction.	4/17/95	4/21/00, 65 FR 21315	120–04–1213.
5–40–1650	Permits	4/17/95	4/21/00, 65 FR 21315	120–04–1214.
Article 13 Emission Standards for Kraft Pulp and Paper Mills (Rule 4–13)				
5–40–1660	Applicability and Designation of Affected Facility.	4/01/99	10/19/07, 72 FR 59207.	
5–40–1670	Definitions of cross recovery furnace, kraft pulp mill, lime kiln, recovery furnace, smelt dissolving tank.	4/17/95	4/21/00, 65 FR 21315	120–04–1302 Remaining definitions are Federally enforceable as part of the Section 111(d) plan for kraft pulp mills (*see*, § 62.11610).
	Definitions	4/01/99	10/19/07, 72 FR 59207	Added: Neutral sulfite semichemical pulping operation, New design recovery furnace, Pulp and paper mill, Semichemical pulping process; Straight kraft recovery furnace, Revised: Cross recovery furnace.
5–40–1680	Standard for Particulate Matter	4/17/95	4/21/00, 65 FR 21315	120–04–1303.
5–40–1700	Control Technology Guidelines	4/17/95	4/21/00, 65 FR 21315	120–04–1305.
5–40–1710	Standard for Visible Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–1306.
5–40–1720	Standard for Fugitive Dust/Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–1307.
5–40–1750	Compliance	4/01/99	10/19/07, 72 FR 59207.	
5–40–1760	Test Methods and Procedures	4/17/95	4/21/00, 65 FR 21315	120–04–1311.
5–40–1770A	Monitoring	4/17/95	4/21/00, 65 FR 21315	120–04–1312A. **Note**: Sections 5–40–1770B. and C. are Federally enforceable as part of the Section111(d) plan for kraft pulp mills (*see*, § 62.11610).
5–40–1780A	Notification, Records and Reporting	4/17/95	4/21/00, 65 FR 21315	120–04–1313A. **Note**: Sections 5–40–1780B. through D. are Federally enforceable as part of the Section 111(d) plan for kraft pulp mills (*see*, § 62.11610).
5–40–1790	Registration	4/17/95	4/21/00, 65 FR 21315	120–04–1314.

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State citation	Title/subject	State effective date	EPA approval date	Explanation [former SIP citation]
5–40–1800	Facility and Control Equipment Maintenance or Malfunction.	4/17/95	4/21/00, 65 FR 21315	120–04–1315.
5–40–1810	Permits	4/01/99	10/19/07, 72 FR 59207.	
Article 14 Emission Standards for Sand and Gravel Processing Operations and Stone Quarrying and Processing Operations (Rule 4–14)				
5–40–1820	Applicability and Designation of Affected Facility.	4/17/95	4/21/00, 65 FR 21315	120–04–1401.
5–40–1830	Definitions	4/17/95	4/21/00, 65 FR 21315	120–04–1402.
5–40–1840	Standard for Particulate Matter	4/17/95	4/21/00, 65 FR 21315	120–04–1403.
5–40–1850	Standard for Visible Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–1404.
5–40–1860	Standard for Fugitive Dust/Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–1405.
5–40–1890	Compliance	4/17/95	4/21/00, 65 FR 21315	120–04–1408.
5–40–1900	Test Methods and Procedures	4/17/95	4/21/00, 65 FR 21315	120–04–1409.
5–40–1910	Monitoring	4/17/95	4/21/00, 65 FR 21315	120–04–1410.
5–40–1920	Notification, Records and Reporting	4/17/95	4/21/00, 65 FR 21315	120–04–1411.
5–40–1930	Registration	4/17/95	4/21/00, 65 FR 21315	120–04–1412.
5–40–1940	Facility and Control Equipment Maintenance or Malfunction.	4/17/95	4/21/00, 65 FR 21315	120–04–1413.
5–40–1950	Permits	4/17/95	4/21/00, 65 FR 21315	120–04–1414.
Article 15 Emission Standards for Coal Preparation Plants (Rule 4–15)				
5–40–1960	Applicability and Designation of Affected Facility.	4/17/95	4/21/00, 65 FR 21315	120–04–1501.
5–40–1970	Definitions	4/17/95	4/21/00, 65 FR 21315	120–04–1502.
5–40–1980	Standard for Particulate Matter	4/17/95	4/21/00, 65 FR 21315	120–04–1503.
5–40–1990	Standard for Visible Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–1504.
5–40–2000	Standard for Fugitive Dust/Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–1505.
5–40–2030	Compliance	4/17/95	4/21/00, 65 FR 21315	120–04–1508.
5–40–2040	Test Methods and Procedures	4/17/95	4/21/00, 65 FR 21315	120–04–1509.
5–40–2050	Monitoring	4/17/95	4/21/00, 65 FR 21315	120–04–1510.
5–40–2060	Notification, Records and Reporting	4/17/95	4/21/00, 65 FR 21315	120–04–1511.
5–40–2070	Registration	4/17/95	4/21/00, 65 FR 21315	120–04–1512.
5–40–2080	Facility and Control Equipment Maintenance or Malfunction.	4/17/95	4/21/00, 65 FR 21315	120–04–1513.
5–40–2090	Permits	4/17/95	4/21/00, 65 FR 21315	120–04–1514.
Article 16 Emission Standards for Portland Cement Plants (Rule 4–16)				
5–40–2100	Applicability and Designation of Affected Facility.	4/17/95	4/21/00, 65 FR 21315	120–04–1601.
5–40–2110	Definitions	4/17/95	4/21/00, 65 FR 21315	120–04–1602.
5–40–2120	Standard for Particulate Matter	4/17/95	4/21/00, 65 FR 21315	120–04–1603.
5–40–2130	Standard for Sulfur Dioxide	4/17/95	4/21/00, 65 FR 21315	120–04–1604.
5–40–2140	Standard for Visible Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–1605.
5–40–2150	Standard for Fugitive Dust/Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–1606.
5–40–2180	Compliance	4/17/95	4/21/00, 65 FR 21315	120–04–1609.
5–40–2190	Test Methods and Procedures	4/17/95	4/21/00, 65 FR 21315	120–04–1610.
5–40–2200	Monitoring	4/17/95	4/21/00, 65 FR 21315	120–04–1611.
5–40–2210	Notification, Records and Reporting	4/17/95	4/21/00, 65 FR 21315	120–04–1612.
5–40–2220	Registration	4/17/95	4/21/00, 65 FR 21315	120–04–1613.
5–40–2230	Facility and Control Equipment Maintenance or Malfunction.	4/17/95	4/21/00, 65 FR 21315	120–04–1614.
5–40–2240	Permits	4/17/95	4/21/00, 65 FR 21315	120–04–1615.
Article 17 Emission Standards for Woodworking Operations (Rule 4–17)				
5–40–2250	Applicability and Designation of Affected Facility.	4/17/95	4/21/00, 65 FR 21315	120–04–1701.
5–40–2260	Definitions	4/17/95	4/21/00, 65 FR 21315	120–04–1702.
5–40–2270	Standard for Particulate Matter	4/17/95	4/21/00, 65 FR 21315	120–04–1703.
5–40–2280	Standard for Visible Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–1704.
5–40–2290	Standard for Fugitive Dust/Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–1705.
5–40–2320	Compliance	4/17/95	4/21/00, 65 FR 21315	120–04–1708.
5–40–2330	Test Methods and Procedures	4/17/95	4/21/00, 65 FR 21315	120–04–1709.
5–40–2340	Monitoring	4/17/95	4/21/00, 65 FR 21315	120–04–1710.
5–40–2350	Notification, Records and Reporting	4/17/95	4/21/00, 65 FR 21315	120–04–1711.
5–40–2360	Registration	4/17/95	4/21/00, 65 FR 21315	120–04–1712.

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State citation	Title/subject	State effective date	EPA approval date	Explanation [former SIP citation]
5–40–2370	Facility and Control Equipment Maintenance or Malfunction.	4/17/95	4/21/00, 65 FR 21315	120–04–1713.
5–40–2380	Permits	4/17/95	4/21/00, 65 FR 21315	120–04–1714.
Article 18 Emission Standards for Primary and Secondary Metal Operations (Rule 4–18)				
5–40–2390	Applicability and Designation of Affected Facility.	4/17/95	4/21/00, 65 FR 21315	120–04–1801.
5–40–2400	Definitions	4/17/95	4/21/00, 65 FR 21315	120–04–1802.
5–40–2410	Standard for Particulate Matter	4/17/95	4/21/00, 65 FR 21315	120–04–1803.
5–40–2420	Standard for Sulfur Oxides	4/17/95	4/21/00, 65 FR 21315	120–04–1804.
5–40–2430	Standard for Visible Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–1805.
5–40–2440	Standard for Fugitive Dust/Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–1806.
5–40–2470	Compliance	4/17/95	4/21/00, 65 FR 21315	120–04–1809.
5–40–2480	Test Methods and Procedures	4/17/95	4/21/00, 65 FR 21315	120–04–1810.
5–40–2490	Monitoring	4/17/95	4/21/00, 65 FR 21315	120–04–1811.
5–40–2500	Notification, Records and Reporting	4/17/95	4/21/00, 65 FR 21315	120–04–1812.
5–40–2510	Registration	4/17/95	4/21/00, 65 FR 21315	120–04–1813.
5–40–2520	Facility and Control Equipment Maintenance or Malfunction.	4/17/95	4/21/00, 65 FR 21315	120–04–1814.
5–40–2530	Permits	4/17/95	4/21/00, 65 FR 21315	120–04–1815.
Article 19 Emission Standards for Lightweight Aggregate Process Operations (Rule 4–19)				
5–40–2540	Applicability and Designation of Affected Facility.	4/17/95	4/21/00, 65 FR 21315	120–04–1901.
5–40–2550	Definitions	4/17/95	4/21/00, 65 FR 21315	120–04–1902.
5–40–2560	Standard for Particulate Matter	4/17/95	4/21/00, 65 FR 21315	120–04–1903.
5–40–2570	Standard for Sulfur Oxides	4/17/95	4/21/00, 65 FR 21315	120–04–1904.
5–40–2580	Standard for Visible Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–1905.
5–40–2590	Standard for Fugitive Dust/Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–1906.
5–40–2620	Compliance	4/17/95	4/21/00, 65 FR 21315	120–04–1909.
5–40–2630	Test Methods and Procedures	4/17/95	4/21/00, 65 FR 21315	120–04–1910.
5–40–2640	Monitoring	4/17/95	4/21/00, 65 FR 21315	120–04–1911.
5–40–2650	Notification, Records and Reporting	4/17/95	4/21/00, 65 FR 21315	120–04–1912.
5–40–2660	Registration	4/17/95	4/21/00, 65 FR 21315	120–04–1913.
5–40–2670	Facility and Control Equipment Maintenance or Malfunction.	4/17/95	4/21/00, 65 FR 21315	120–04–1914.
5–40–2680	Permits	4/17/95	4/21/00, 65 FR 21315	120–04–1915.
Article 20 Emission Standards for Feed Manufacturing Operations (Rule 4–20)				
5–40–2690	Applicability and Designation of Affected Facility.	4/17/95	4/21/00, 65 FR 21315	120–04–2001.
5–40–2700	Definitions	4/17/95	4/21/00, 65 FR 21315	120–04–2002.
5–40–2710	Standard for Particulate Matter	4/17/95	4/21/00, 65 FR 21315	120–04–2003.
5–40–2720	Standard for Visible Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–2004.
5–40–2730	Standard for Fugitive Dust/Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–2005.
5–40–2760	Compliance	4/17/95	4/21/00, 65 FR 21315	120–04–2008.
5–40–2770	Test Methods and Procedures	4/17/95	4/21/00, 65 FR 21315	120–04–2009.
5–40–2780	Monitoring	4/17/95	4/21/00, 65 FR 21315	120–04–2010.
5–40–2790	Notification, Records and Reporting	4/17/95	4/21/00, 65 FR 21315	120–04–2011.
5–40–2800	Registration	4/17/95	4/21/00, 65 FR 21315	120–04–2012.
5–40–2810	Facility and Control Equipment Maintenance or Malfunction.	4/17/95	4/21/00, 65 FR 21315	120–04–2013.
5–40–2820	Permits	4/17/95	4/21/00, 65 FR 21315	120–04–2014.
Article 21 Emission Standards for Sulfuric Acid Production Plants (Rule 4–21)				
5–40–2830	Applicability and Designation of Affected Facility.	4/17/95	4/21/00, 65 FR 21315	120–04–2101.
5–40–2840	Definitions	4/17/95	4/21/00, 65 FR 21315	120–04–2102.
5–40–2850	Standard for Sulfur Dioxide	4/17/95	4/21/00, 65 FR 21315	120–04–2103.
5–40–2870	Standard for Visible Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–2105.
5–40–2880	Standard for Fugitive Dust/Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–2106.
5–40–2910	Compliance	4/17/95	4/21/00, 65 FR 21315	120–04–2109.
5–40–2920	Test Methods and Procedures	4/17/95	4/21/00, 65 FR 21315	120–04–2110.
5–40–2930	Monitoring	2/1/02	3/3/06, 71 FR 10838.	
5–40–2940	Notification, Records and Reporting	4/17/95	4/21/00, 65 FR 21315	120–04–2112.
5–40–2950	Registration	4/17/95	4/21/00, 65 FR 21315	120–04–2113.

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5–40–2960	Facility and Control Equipment Maintenance or Malfunction.	4/17/95	4/21/00, 65 FR 21315	120–04–2114.
5–40–2970	Permits	4/17/95	4/21/00, 65 FR 21315	120–04–2115.
Article 22 Emission Standards for Sulfur Recovery Operations (Rule 4–22)				
5–40–2980	Applicability and Designation of Affected Facility.	4/17/95	4/21/00, 65 FR 21315	120–04–2201.
5–40–2990	Definitions	4/17/95	4/21/00, 65 FR 21315	120–04–2202.
5–40–3000	Standard for Sulfur Dioxide	4/17/95	4/21/00, 65 FR 21315	120–04–2203.
5–40–3010	Standard for Visible Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–2204.
5–40–3020	Standard for Fugitive Dust/Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–2205.
5–40–3050	Compliance	4/17/95	4/21/00, 65 FR 21315	120–04–2208.
5–40–3060	Test Methods and Procedures	4/17/95	4/21/00, 65 FR 21315	120–04–2209.
5–40–3070	Monitoring	4/17/95	4/21/00, 65 FR 21315	120–04–2210.
5–40–3080	Notification, Records and Reporting	4/17/95	4/21/00, 65 FR 21315	120–04–2211.
5–40–3090	Registration	4/17/95	4/21/00, 65 FR 21315	20–04–2212.
5–40–3100	Facility and Control Equipment Maintenance or Malfunction.	4/17/95	4/21/00, 65 FR 21315	120–04–2213.
5–40–3110	Permits	4/17/95	4/21/00, 65 FR 21315	120–04–2214.
Article 23 Emission Standards for Nitric Acid Production Units (Rule 4–23)				
5–40–3120	Applicability and Designation of Affected Facility.	4/17/95	4/21/00, 65 FR 21315	120–04–2301.
5–40–3130	Definitions	4/17/95	4/21/00, 65 FR 21315	120–04–2302.
5–40–3140	Standard for Nitrogen Oxides	4/17/95	4/21/00, 65 FR 21315	120–04–2303.
5–40–3150	Standard for Visible Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–2304.
5–40–3160	Standard for Fugitive Dust/Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–2305.
5–40–3190	Compliance	4/17/95	4/21/00, 65 FR 21315	120–04–2308.
5–40–3200	Test Methods and Procedures	4/17/95	4/21/00, 65 FR 21315	120–04–2309.
5–40–3210	Monitoring	4/17/95	4/21/00, 65 FR 21315	120–04–2310.
5–40–3220	Notification, Records and Reporting	4/17/95	4/21/00, 65 FR 21315	120–04–2311.
5–40–3230	Registration	4/17/95	4/21/00, 65 FR 21315	120–04–2312.
5–40–3240	Facility and Control Equipment Maintenance or Malfunction.	4/17/95	4/21/00, 65 FR 21315	120–04–2313.
5–40–3250	Permits	4/17/95	4/21/00, 65 FR 21315	120–04–2314.
Article 24 Emission Standards for Solvent Metal Cleaning Operations Using Non-Halogenated Solvents (Rule 4–24)				
5–40–3260	Applicability and Designation of Affected Facility.	3/24/04	5/17/05, 70 FR 28215.	
5–40–3270	Definitions	4/1/97	11/3/99, 64 FR 59635.	
5–40–3280	Standard for Volatile Organic Compounds.	4/1/97	11/3/99, 64 FR 59635.	
5–40–3290	Control Technology Guidelines	4/1/97	11/3/99, 64 FR 59635.	
5–40–3300	Standard for Visible Emissions	4/1/97	11/3/99, 64 FR 59635.	
5–40–3310	Standard for Fugitive Dust/Emissions	4/1/97	11/3/99, 64 FR 59635.	
5–40–3340	Compliance	4/1/97	11/3/99, 64 FR 59635.	
5–40–3350	Test Methods and Procedures	4/1/97	11/3/99, 64 FR 59635.	
5–40–3360	Monitoring	4/1/97	11/3/99, 64 FR 59635.	
5–40–3370	Notification, Records and Reporting	4/1/97	11/3/99, 64 FR 59635.	
5–40–3380	Registration	4/1/97	11/3/99, 64 FR 59635.	
5–40–3390	Facility and Control Equipment Maintenance or Malfunction.	4/1/97	11/3/99, 64 FR 59635.	
5–40–3400	Permits	4/1/97	11/3/99, 64 FR 59635.	
Article 25 Emission Standards for Volatile Organic Compound Storage and Transfer Operations (Rule 4–25)				
5–40–3410	Applicability and Designation of Affected Facility.	4/17/95	4/21/00, 65 FR 21315	120–04–2501.
5–40–3420	Definitions	4/17/95	4/21/00, 65 FR 21315	120–04–2502.
5–40–3430	Standard for Volatile Organic Compounds.	4/17/95	4/21/00, 65 FR 21315	120–04–2503.
5–40–3440	Control Technology Guidelines	4/17/95	4/21/00, 65 FR 21315	120–04–2504.
5–40–3450	Standard for Visible Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–2505.
5–40–3460	Standard for Fugitive Dust/Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–2506.
5–40–3490	Compliance	4/17/95	4/21/00, 65 FR 21315	120–04–2509.
5–40–3500	Test Methods and Procedures	4/17/95	4/21/00, 65 FR 21315	120–04–2510.
5–40–3510	Monitoring	4/17/95	4/21/00, 65 FR 21315	120–04–2511.
5–40–3520	Notification, Records and Reporting	4/17/95	4/21/00, 65 FR 21315	120–04–2512.

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5–40–3530	Registration	4/17/95	4/21/00, 65 FR 21315	120–04–2513.
5–40–3540	Facility and Control Equipment Maintenance or Malfunction.	4/17/95	4/21/00, 65 FR 21315	120–04–2514.
5–40–3550	Permits	4/17/95	4/21/00, 65 FR 21315	120–04–2515.
Article 26 Emission Standards for Large Coating Application Systems (Rule 4–26)				
5–40–3560	Applicability and Designation of Affected Facility.	4/17/95	4/21/00, 65 FR 21315	120–04–2601.
5–40–3570	Definitions	4/17/95	4/21/00, 65 FR 21315	120–04–2602.
5–40–3580	Standard for Volatile Organic Compounds.	4/17/95	4/21/00, 65 FR 21315	120–04–2603.
5–40–3590	Control Technology Guidelines	4/17/95	4/21/00, 65 FR 21315	120–04–2604.
5–40–3600	Standard for Visible Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–2605.
5–40–3610	Standard for Fugitive Dust/Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–2606.
5–40–3640	Compliance	4/17/95	4/21/00, 65 FR 21315	120–04–2609.
5–40–3650	Test Methods and Procedures	4/17/95	4/21/00, 65 FR 21315	120–04–2610.
5–40–3660	Monitoring	4/17/95	4/21/00, 65 FR 21315	120–04–2611.
5–40–3670	Notification, Records and Reporting	4/17/95	4/21/00, 65 FR 21315	120–04–2612.
5–40–3680	Registration	4/17/95	4/21/00, 65 FR 21315	120–04–2613.
5–40–3690	Facility and Control Equipment Maintenance or Malfunction.	4/17/95	4/21/00, 65 FR 21315	120–04–2614.
5–40–3700	Permits	4/17/95	4/21/00, 65 FR 21315	120–04–2615.
Article 27 Emission Standards for Magnet Wire Coating Application Systems (Rule 4–27)				
5–40–3710	Applicability and Designation of Affected Facility.	4/17/95	4/21/00, 65 FR 21315	120–04–2701.
5–40–3720	Definitions	4/17/95	4/21/00, 65 FR 21315	120–04–2702.
5–40–3730	Standard for Volatile Organic Compounds.	4/17/95	4/21/00, 65 FR 21315	120–04–2703.
5–40–3740	Control Technology Guidelines	4/17/95	4/21/00, 65 FR 21315	120–04–2704.
5–40–3750	Standard for Visible Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–2705.
5–40–3760	Standard for Fugitive Dust/Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–2706.
5–40–3790	Compliance	4/17/95	4/21/00, 65 FR 21315	120–04–2709.
5–40–3800	Test Methods and Procedures	4/17/95	4/21/00, 65 FR 21315	120–04–2710.
5–40–3810	Monitoring	4/17/95	4/21/00, 65 FR 21315	120–04–2711.
5–40–3820	Notification, Records and Reporting	4/17/95	4/21/00, 65 FR 21315	120–04–2712.
5–40–3830	Registration	4/17/95	4/21/00, 65 FR 21315	120–04–2713.
5–40–3840	Facility and Control Equipment Maintenance or Malfunction.	4/17/95	4/21/00, 65 FR 21315	120–04–2714.
5–40–3850	Permits	4/17/95	4/21/00, 65 FR 21315	120–04–2715.
Article 28 Emission Standards for Automobile and Light Duty Truck Coating Application Systems (Rule 4–28)				
5–40–3860	Applicability and Designation of Affected Facility.	4/17/95	4/21/00, 65 FR 21315	120–04–2801.
5–40–3870	Definitions	4/17/95	4/21/00, 65 FR 21315	120–04–2802.
5–40–3880	Standard for Volatile Organic Compounds.	4/17/95	4/21/00, 65 FR 21315	120–04–2803.
5–40–3890	Control Technology Guidelines	4/17/95	4/21/00, 65 FR 21315	120–04–2804.
5–40–3900	Standard for Visible Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–2805.
5–40–3910	Standard for Fugitive Dust/Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–2806.
5–40–3940	Compliance	4/17/95	4/21/00, 65 FR 21315	120–04–2809.
5–40–3950	Test Methods and Procedures	4/17/95	4/21/00, 65 FR 21315	120–04–2810.
5–40–3960	Monitoring	4/17/95	4/21/00, 65 FR 21315	120–04–2811.
5–40–3970	Notification, Records and Reporting	4/17/95	4/21/00, 65 FR 21315	120–04–2812.
5–40–3980	Registration	4/17/95	4/21/00, 65 FR 21315	120–04–2813.
5–40–3990	Facility and Control Equipment Maintenance or Malfunction.	4/17/95	4/21/00, 65 FR 21315	120–04–2814.
5–40–4000	Permits	4/17/95	4/21/00, 65 FR 21315	120–04–2815.
Article 29 Emission Standards for Can Coating Application Systems (Rule 4–29)				
5–40–4010	Applicability and Designation of Affected Facility.	4/17/95	4/21/00, 65 FR 21315	120–04–2901.
5–40–4020	Definitions	4/17/95	4/21/00, 65 FR 21315	120–04–2902.
5–40–4030	Standard for Volatile Organic Compounds.	4/17/95	4/21/00, 65 FR 21315	120–04–2903.
5–40–4040	Control Technology Guidelines	4/17/95	4/21/00, 65 FR 21315	120–04–2904.
5–40–4050	Standard for Visible Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–2905.

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5–40–4060	Standard for Fugitive Dust/Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–2906.
5–40–4090	Compliance	4/17/95	4/21/00, 65 FR 21315	120–04–2909.
5–40–4100	Test Methods and Procedures	4/17/95	4/21/00, 65 FR 21315	120–04–2910.
5–40–4110	Monitoring	4/17/95	4/21/00, 65 FR 21315	120–04–2911.
5–40–4120	Notification, Records and Reporting	4/17/95	4/21/00, 65 FR 21315	120–04–2912.
5–40–4130	Registration	4/17/95	4/21/00, 65 FR 21315	120–04–2913.
5–40–4140	Facility and Control Equipment Maintenance or Malfunction.	4/17/95	4/21/00, 65 FR 21315	120–04–2914.
5–40–4150	Permits	4/17/95	4/21/00, 65 FR 21315	120–04–2915.
Article 30 Emission Standards for Metal Coil Coating Application Systems (Rule 4–30)				
5–40–4160	Applicability and Designation of Affected Facility.	4/17/95	4/21/00, 65 FR 21315	120–04–3001.
5–40–4170	Definitions	4/17/95	4/21/00, 65 FR 21315	120–04–3002.
5–40–4180	Standard for Volatile Organic Compounds.	4/17/95	4/21/00, 65 FR 21315	120–04–3003.
5–40–4190	Control Technology Guidelines	4/17/95	4/21/00, 65 FR 21315	120–04–3004.
5–40–4200	Standard for Visible Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–3005.
5–40–4210	Standard for Fugitive Dust/Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–3006.
5–40–4240	Compliance	4/17/95	4/21/00, 65 FR 21315	120–04–3009.
5–40–4250	Test Methods and Procedures	4/17/95	4/21/00, 65 FR 21315	120–04–3010.
5–40–4260	Monitoring	4/17/95	4/21/00, 65 FR 21315	120–04–3011.
5–40–4270	Notification, Records and Reporting	4/17/95	4/21/00, 65 FR 21315	120–04–3012.
5–40–4280	Registration	4/17/95	4/21/00, 65 FR 21315	120–04–3013.
5–40–4290	Facility and Control Equipment Maintenance or Malfunction.	4/17/95	4/21/00, 65 FR 21315	120–04–3014.
5–40–4300	Permits	4/17/95	4/21/00, 65 FR 21315	120–04–3015.
Article 31 Emission Standards for Paper and Fabric Coating Application Systems (Rule 4–31)				
5–40–4310	Applicability and Designation of Affected Facility.	4/17/95	4/21/00, 65 FR 21315	120–04–3101.
5–40–4320	Definitions	4/17/95	4/21/00, 65 FR 21315	120–04–3102.
5–40–4330	Standard for Volatile Organic Compounds.	4/17/95	4/21/00, 65 FR 21315	120–04–3103.
5–40–4340	Control Technology Guidelines	4/17/95	4/21/00, 65 FR 21315	120–04–3104.
5–40–4350	Standard for Visible Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–3105.
5–40–4360	Standard for Fugitive Dust/Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–3106.
5–40–4390	Compliance	4/17/95	4/21/00, 65 FR 21315	120–04–3109.
5–40–4400	Test Methods and Procedures	4/17/95	4/21/00, 65 FR 21315	120–04–3110.
5–40–4410	Monitoring	4/17/95	4/21/00, 65 FR 21315	120–04–3111.
5–40–4420	Notification, Records and Reporting	4/17/95	4/21/00, 65 FR 21315	120–04–3112.
5–40–4430	Registration	4/17/95	4/21/00, 65 FR 21315	120–04–3113.
5–40–4440	Facility and Control Equipment Maintenance or Malfunction.	4/17/95	4/21/00, 65 FR 21315	120–04–3114.
5–40–4450	Permits	4/17/95	4/21/00, 65 FR 21315	120–04–3115.
Article 32 Emission Standards for Vinyl Coating Application Systems (Rule 4–32)				
5–40–4460	Applicability and Designation of Affected Facility.	4/17/95	4/21/00, 65 FR 21315	120–04–3201.
5–40–4470	Definitions	4/17/95	4/21/00, 65 FR 21315	120–04–3202.
5–40–4480	Standard for Volatile Organic Compounds.	4/17/95	4/21/00, 65 FR 21315	120–04–3203.
5–40–4490	Control Technology Guidelines	4/17/95	4/21/00, 65 FR 21315	120–04–3204.
5–40–4500	Standard for Visible Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–3205.
5–40–4510	Standard for Fugitive Dust/Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–3206.
5–40–4540	Compliance	4/17/95	4/21/00, 65 FR 21315	120–04–3209.
5–40–4550	Test Methods and Procedures	4/17/95	4/21/00, 65 FR 21315	120–04–3210.
5–40–4560	Monitoring	4/17/95	4/21/00, 65 FR 21315	120–04–3211.
5–40–4570	Notification, Records and Reporting	4/17/95	4/21/00, 65 FR 21315	120–04–3212.
5–40–4580	Registration	4/17/95	4/21/00, 65 FR 21315	120–04–3213.
5–40–4590	Facility and Control Equipment Maintenance or Malfunction.	4/17/95	4/21/00, 65 FR 21315	120–04–3214.
5–40–4600	Permits	4/17/95	4/21/00, 65 FR 21315	120–04–3215.
Article 33 Emission Standards for Metal Furniture Coating Application Systems (Rule 4–33)				
5–40–4610	Applicability and Designation of Affected Facility.	4/17/95	4/21/00, 65 FR 21315	120–04–3301.

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State citation	Title/subject	State effective date	EPA approval date	Explanation [former SIP citation]
5–40–4620	Definitions	4/17/95	4/21/00, 65 FR 21315	120–04–3302.
5–40–4630	Standard for Volatile Organic Compounds.	4/17/95	4/21/00, 65 FR 21315	120–04–3303.
5–40–4640	Control Technology Guidelines	4/17/95	4/21/00, 65 FR 21315	120–04–3304.
5–40–4650	Standard for Visible Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–3305.
5–40–4660	Standard for Fugitive Dust/Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–3306.
5–40–4690	Compliance	4/17/95	4/21/00, 65 FR 21315	120–04–3309.
5–40–4700	Test Methods and Procedures	4/17/95	4/21/00, 65 FR 21315	120–04–3310.
5–40–4710	Monitoring	4/17/95	4/21/00, 65 FR 21315	120–04–3311.
5–40–4720	Notification, Records and Reporting	4/17/95	4/21/00, 65 FR 21315	120–04–3312.
5–40–4730	Registration	4/17/95	4/21/00, 65 FR 21315	120–04–3313.
5–40–4740	Facility and Control Equipment Maintenance or Malfunction.	4/17/95	4/21/00, 65 FR 21315	120–04–3314.
5–40–4750	Permits	4/17/95	4/21/00, 65 FR 21315	120–04–3315.
Article 34 Emission Standards for Miscellaneous Metal Parts and Products Coating Application Systems (Rule 4–34)				
5–40–4760	Applicability and Designation of Affected Facility.	4/17/95	4/21/00, 65 FR 21315	120–04–3401.
5–40–4770	Definitions	4/17/95	4/21/00, 65 FR 21315	120–04–3402.
5–40–4780	Standard for Volatile Organic Compounds.	4/17/95	4/21/00, 65 FR 21315	120–04–3403.
5–40–4790	Control Technology Guidelines	4/17/95	4/21/00, 65 FR 21315	120–04–3404.
5–40–4800	Standard for Visible Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–3405.
5–40–4810	Standard for Fugitive Dust/Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–3406.
5–40–4840	Compliance	4/17/95	4/21/00, 65 FR 21315	120–04–3409.
5–40–4850	Test Methods and Procedures	4/17/95	4/21/00, 65 FR 21315	120–04–3410.
5–40–4860	Monitoring	4/17/95	4/21/00, 65 FR 21315	120–04–3411.
5–40–4870	Notification, Records and Reporting	4/17/95	4/21/00, 65 FR 21315	120–04–3412.
5–40–4880	Registration	4/17/95	4/21/00, 65 FR 21315	120–04–3413.
5–40–4890	Facility and Control Equipment Maintenance or Malfunction.	4/17/95	4/21/00, 65 FR 21315	120–04–3414.
5–40–4900	Permits	4/17/95	4/21/00, 65 FR 21315	120–04–3415.
Article 35 Emission Standards for Flatwood Paneling Coating Application Systems (Rule 4–35)				
5–40–4910	Applicability and Designation of Affected Facility.	4/17/95	4/21/00, 65 FR 21315	120–04–3501.
5–40–4920	Definitions	4/17/95	4/21/00, 65 FR 21315	120–04–3502.
5–40–4930	Standard for Volatile Organic Compounds.	4/17/95	4/21/00, 65 FR 21315	120–04–3503.
5–40–4940	Control Technology Guidelines	4/17/95	4/21/00, 65 FR 21315	120–04–3504.
5–40–4950	Standard for Visible Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–3505.
5–40–4960	Standard for Fugitive Dust/Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–3506.
5–40–4990	Compliance	4/17/95	4/21/00, 65 FR 21315	120–04–3509.
5–40–5000	Test Methods and Procedures	4/17/95	4/21/00, 65 FR 21315	120–04–3510.
5–40–5010	Monitoring	4/17/95	4/21/00, 65 FR 21315	120–04–3511.
5–40–5020	Notification, Records and Reporting	4/17/95	4/21/00, 65 FR 21315	120–04–3512.
5–40–5030	Registration	4/17/95	4/21/00, 65 FR 21315	120–04–3513.
5–40–5040	Facility and Control Equipment Maintenance or Malfunction.	4/17/95	4/21/00, 65 FR 21315	120–04–3514.
5–40–5050	Permits	4/17/95	4/21/00, 65 FR 21315	120–04–3515.
Article 36 Flexographic, Packaging Rotogravure, and Publication Rotogravure Printing Lines (Rule 4–36)				
5–40–5060	Applicability and Designation of Affected Facility.	4/1/96 10/4/06	3/2/07, 72 FR 9441.	
5–40–5070	Definitions	4/1/96	3/12/97, 62 FR 11334	§ 52.2465(c)(113)(i)(B)(4).
5–40–5080	Standard for Volatile Organic Compounds.	4/1/96	3/12/97, 62 FR 11334.	
5–40–5090	Standard for Visible Emissions	4/1/96	3/12/97, 62 FR 11334.	
5–40–5100	Standard for Fugitive Dust/Emissions	4/1/96	3/12/97, 62 FR 11334.	
5–40–5130	Compliance	4/1/96	3/12/97, 62 FR 11334.	
5–40–5140	Test Methods and Procedures	4/1/96	3/12/97, 62 FR 11334.	
5–40–5150	Monitoring	4/1/96	3/12/97, 62 FR 11334.	
5–40–5160	Notification, Records and Reporting	4/1/96	3/12/97, 62 FR 11334.	
5–40–5170	Registration	4/1/96	3/12/97, 62 FR 11334.	
5–40–5180	Facility and Control Equipment Maintenance or Malfunction.	4/1/96	3/12/97, 62 FR 11334.	
5–40–5190	Permits	4/1/96	3/12/97, 62 FR 11334.	

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State citation	Title/subject	State effective date	EPA approval date	Explanation [former SIP citation]
Article 37 Emission Standards for Petroleum Liquid Storage and Transfer Operations (Rule 4–37)				
5–40–5200	Applicability and Designation of Affected Facility.	4/1/96 10/4/06	3/2/07, 72 FR 9441.	
5–40–5210	Definitions	2/1/02	3/3/06, 71 FR 10838.	
5–40–5220	Standard for Volatile Organic Compounds.	3/24/04	4/27/05, 70 FR 21625.	
5–40–5230	Control Technology Guidelines	2/1/02	3/3/06, 71 FR 10838.	
5–40–5240	Standard for Visible Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–3705.
5–40–5250	Standard for Fugitive Dust/Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–3706.
5–40–5280	Compliance	4/17/95	4/21/00, 65 FR 21315	120–04–3709.
5–40–5290	Test Methods and Procedures	4/17/95	4/21/00, 65 FR 21315	120–04–3710.
5–40–5300	Monitoring	4/17/95	4/21/00, 65 FR 21315	120–04–3711.
5–40–5310	Notification, Records and Reporting	4/17/95	4/21/00, 65 FR 21315	120–04–3712.
5–40–5320	Registration	4/17/95	4/21/00, 65 FR 21315	120–04–3713.
5–40–5330	Facility and Control Equipment Maintenance or Malfunction.	4/17/95	4/21/00, 65 FR 21315	120–04–3714.
5–40–5340	Permits	4/17/95	4/21/00, 65 FR 21315	120–04–3715.
Article 39 Emission Standards for Asphalt Paving Operations (Rule 4–39)				
5–40–5490	Applicability and Designation of Affected Facility.	4/17/95	4/21/00, 65 FR 21315	120–04–3901.
5–40–5500	Definitions	4/17/95	4/21/00, 65 FR 21315	120–04–3902.
5–40–5510	Standard for Volatile Organic Compounds.	4/17/95	4/21/00, 65 FR 21315	120–04–3903.
5–40–5520	Standard for Visible Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–3904.
5–40–5530	Standard for Fugitive Dust/Emissions	4/17/95	4/21/00, 65 FR 21315	120–04–3905.
5–40–5560	Compliance	4/17/95	4/21/00, 65 FR 21315	120–04–3908.
5–40–5570	Test Methods and Procedures	4/17/95	4/21/00, 65 FR 21315	120–04–3909.
5–40–5580	Monitoring	4/17/95	4/21/00, 65 FR 21315	120–04–3910.
5–40–5590	Notification, Records and Reporting	4/17/95	4/21/00, 65 FR 21315	120–04–3911.
Article 40 Emission Standards for Open Burning (Rule 4–40)				
5–40–5600	Applicability	10/18/06	3/19/09, 74 FR 11661	Provisions of Article 40 expanded to new localities in the emissions control areas.
5–40–5610	Definitions	10/18/06	3/19/09, 74 FR 11661	Terms added: Air curtain incinerator, Clean lumber, Wood waste, and Yard waste. Terms revised: Clean burning waste, Clean wood, Commercial waste, Construction waste, Debris waste, Demolition waste, Garbage, Hazardous waste, Household waste, Industrial waste, Junkyard, Open burning, Open pit incinerator, Refuse, Sanitary landfill, and Special incineration device.
5–40–5610	All definitions not listed above	4/17/95	4/21/00, 65 FR 21315	120–04–4002.
5–40–5620	Open burning prohibitions	10/18/06	3/19/09, 74 FR 11661.	
5–40–5630	Permissible open burning	10/18/06	3/19/09, 74 FR 11661.	
5–40–5631	Forest Management and Agricultural Practices.	7/1/97	3/12/97, 62 FR 11332	Former Appendix D, effective 4/1/96.
Article 41 Emission Standards for Mobile Sources (Rule 4–41)				
5–40–5650	Applicability and Designation of Affected Facility.	4/17/95	4/21/00, 65 FR 21315	120–04–4101.
5–40–5660	Definitions	4/17/95	4/21/00, 65 FR 21315	120–04–4102.
5–40–5670	Motor Vehicles	4/17/95	4/21/00, 65 FR 21315	120–04–4103.
5–40–5680	Other Mobile Sources	4/17/95	4/21/00, 65 FR 21315	120–04–4104.
5–40–5690	Export/Import of Motor Vehicles	4/17/95	4/21/00, 65 FR 21315	120–04–4105.
Article 42 Emissions Standards for Portable Fuel ContainerSpillage (Rule 4–42)				
5–40–5700	Applicability	3/24/04	6/8/04, 69 FR 31893.	
5–40–5700	Applicability and designation of affected facility.	10/4/06	12/5/07, 72 FR 68511	Revision extends the applicability to include the Fredericksburg VOC Emissions Control Area.

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State citation	Title/subject	State effective date	EPA approval date	Explanation [former SIP citation]
5–40–5710	Definitions	3/24/04	6/8/04, 69 FR 31893.	
5–40–5720	Standard for volatile organic compounds.	10/4/06	12/5/07, 72 FR 68511.	
5–40–5730	Administrative requirements	3/24/04	6/8/04, 69 FR 31893.	
5–40–5740	Compliance	3/24/04	6/8/04, 69 FR 31893.	
5–40–5750	Compliance schedules	10/4/06	12/5/07, 72 FR 68511.	
5–40–5760	Test methods and procedures	3/24/04	6/8/04, 69 FR 31893.	
5–40–5770	Notification, records and reporting	3/24/04	6/8/04, 69 FR 31893.	
Article 43 Municipal Solid Waste Landfills (Rule 4–43)				
5–40–5800	Applicability and Designation of Affected Facility.	1/29/04	12/29/04, 69 FR 77900.	
5–40–5810	Definitions	1/29/04	12/29/04, 69 FR 77900.	
5–40–5820	Standards for Air Emissions	1/29/04	12/29/04, 69 FR 77900.	
5–40–5822	Operational standards for collection and control systems.	1/29/04	12/29/04, 69 FR 77900.	
5–40–5824	Specifications for active collection systems.	1/29/04	12/29/04, 69 FR 77900.	
5–40–5850	Compliance	1/29/04	12/29/04, 69 FR 77900.	
5–40–5855	Compliance schedule	1/29/04	12/29/04, 69 FR 77900.	
5–40–5860	Test methods and procedures	1/29/04	12/29/04, 69 FR 77900.	
5–40–5870	Monitoring	1/29/04	12/29/04, 69 FR 77900.	
5–40–5880	Reporting	1/29/04	12/29/04, 69 FR 77900.	
5–40–5890	Recordkeeping	1/29/04	12/29/04, 69 FR 77900.	
5–40–5900	Registration	1/29/04	12/29/04, 69 FR 77900.	
5–40–5910	Facility and control equipment Maintenance or Malfunction.	1/29/04	12/29/04, 69 FR 77900.	
5–40–5920	Permits	1/29/04	12/29/04, 69 FR 77900.	
Article 47 Emission Standards for Solvent Metal Cleaning Operations in the Northern Virginia Volatile Organic Compound Emissions Control Area (Rule 4–47)				
5–40–6820	Applicability	3/24/04	6/9/04, 69 FR 32277.	
5–40–6830	Definitions	3/24/04	6/9/04, 69 FR 32277.	
5–40–6840	Standards for volatile organic compounds.	3/24/04	6/9/04, 69 FR 32277.	
5–40–6850	Standard for visible emissions	3/24/04	6/9/04, 69 FR 32277.	
5–40–6860	Standard for fugitive dust/emissions	3/24/04	6/9/04, 69 FR 32277.	
5–40–6890	Compliance	3/24/04	6/9/04, 69 FR 32277.	
5–40–6900	Compliance schedules	3/24/04	6/9/04, 69 FR 32277.	
5–40–6910	Test methods and procedures	3/24/04	6/9/04, 69 FR 32277.	
5–40–6920	Monitoring	3/24/04	6/9/04, 69 FR 32277.	
5–40–6930	Notification, records and reporting	3/24/04	6/9/04, 69 FR 32277.	
5–40–6940	Registration	3/24/04	6/9/04, 69 FR 32277.	
5–40–6950	Facility and control equipment Maintenance or Malfunction.	3/24/04	6/9/04, 69 FR 32277.	
5–40–6960	Permits	3/24/04	6/9/04, 69 FR 32277.	
Article 48 Emission Standards for Mobile Equipment Repairand Refinishing (Rule 4–48)				
5–40–6970	Applicability and designation of affected facility.	10/4/06	12/5/07, 72 FR 68511	Revision extends the applicability to include the Fredericksburg VOC Emissions Control Area.
5–40–6980	Definitions	3/24/04	6/24/04, 69 FR 35253.	
5–40–6990	Standards for volatile organic compounds.	3/24/04	6/24/04, 69 FR 35253.	
5–40–7000	Standard for visible emissions	3/24/04	6/24/04, 69 FR 35253.	
5–40–7010	Standard for fugitive dust/emissions	3/24/04	6/24/04, 69 FR 35253.	
5–40–7040	Compliance	3/24/04	6/24/04, 69 FR 35253.	
5–40–7050	Compliance schedule	10/4/06	12/5/07, 72 FR 68511.	
5–40–7060	Test methods and procedures	3/24/04	6/24/04, 69 FR 35253.	
5–40–7070	Monitoring	3/24/04	6/24/0, 69 FR 35253.	
5–40–7080	Notification, records and reporting	3/24/04	6/24/04, 69 FR 35253.	
5–40–7090	Registration	3/24/04	6/24/04, 69 FR 35253.	
5–40–7100	Facility and control equipment Maintenance or Malfunction.	3/24/04	6/24/04, 69 FR 35253.	
5–40–7110	Permits	3/24/04	6/24/04, 69 FR 35253.	

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Article 49 Emission Standards for Architectural and Maintenance Coatings (Rule 4–49)				
5–40–7120	Applicability and designation of affected facility.	10/4/06	12/5/07, 72 FR 68511	Revision extends the applicability to include the Fredericksburg VOC Emissions Control Area.
5–40–7130	Definitions	10/4/06	12/5/07, 72 FR 68511	Revision adds definitions for the following: ASTM, Calcimine recoater, Concrete surface retarder, Conversion varnish, Impacted immersion coating, Nuclear coating, and Thermoplasatic rubber coating and mastic.
5–40–7140	Standard for volatile organic compounds.	10/4/06	12/5/07, 72 FR 68511	Revision adds standards for the following categories: Calcimine recoaters, Conversion varnishes, Concrete surface retarder, Impacted immersion coatings, Nuclear coatings, and Thermoplastic rubber coating and mastic.
5–40–7150	Container Labeling Requirements	3/24/04	5/12/05, 70 FR 24970.	
5–40–7160	Standard for Visible Emissions	3/24/04	5/12/05, 70 FR 24970.	
5–40–7170	Standard for Fugitive Dust/Emissions	3/24/04	5/12/05, 70 FR 24970.	
5–40–7200	Compliance	3/24/04	5/12/05, 70 FR 24970.	
5–40–7210	Compliance schedules	10/4/06	12/5/07, 72 FR 68511.	
5–40–7220	Test Methods and Procedures	3/24/04	5/12/05, 70 FR 24970.	
5–40–7230	Notification, Records and Reporting	3/24/04	5/12/05, 70 FR 24970.	
Article 50 Emission Standards for Consumer Products (Rule 4–50)				
5–40–7240	Applicability	10/4/06	12/5/07, 72 FR 68511	Revision extends the applicability to include the Fredericksburg VOC Emissions Control Area.
5–40–7250	Exemptions	10/4/06	12/5/07, 72 FR 68511.	
5–40–7260	Definitions	10/4/06	12/5/07, 72 FR 68511.	
5–40–7270	Standard for volatile organic compounds.	10/4/06	12/5/07, 72 FR 68511.	
5–40–7280	Alternative control plan (ACP) for consumer products.	3/9/05	1/30/07, 72 FR 4207.	
5–40–7290	Innovative Products	3/9/05	1/30/07, 72 FR 4207.	
5–40–7300	Administrative requirements	3/9/05	1/30/07, 72 FR 4207.	
5–40–7300	Administrative requirements	10/4/06	12/5/07, 72 FR 68511.	
5–40–7320	Compliance	3/9/05	1/30/07, 72 FR 4207.	
5–40–7330	Compliance schedules	10/4/06	12/5/07, 72 FR 68511.	
5–40–7340	Test methods and procedures	3/9/05	1/30/07, 72 FR 4207.	
5–40–7350	Monitoring	3/9/05	1/30/07, 72 FR 4207.	
5–40–7360	Notification, records and reporting	10/4/06	12/5/07, 72 FR 68511.	
Article 53 Emission Standards for Lithographic Printing Processes (Rule 4–53) [Formerly Article 45]				
5–40–7800	Applicability and designation of affected facility.	10/4/06	3/2/07, 72 FR 9441	Revised to include and exempt certain emission control areas.
5–40–7810	Definitions of alcohol, Cleaning solution, fountain solution, lithographic printing, printing process.	4/1/96 10/4/06	3/2/07, 72 FR 9441.	
5–40–7820	Standard for Volatile Organic Compounds.	4/1/96 10/4/06	3/2/07, 72 FR 9441.	
5–40–7840	Standard for Visible Emissions	4/1/96 10/4/06	3/2/07, 72 FR 9441.	
5–40–7850	Standard for Fugitive Dust Emissions	4/1/96 10/4/06	3/2/07, 72 FR 9441.	
5–40–7880	Compliance	10/4/06	3/2/07, 72 FR 9441	Revisions to compliance dates.
5–40–7890	Test Methods and Procedures	4/1/96 10/4/06	3/2/07, 72 FR 9441.	
5–40–7900	Monitoring	4/1/96 10/4/06	3/2/07, 72 FR 9441.	
5–40–7910	Notification, Records and Reporting	4/1/96 10/4/06	3/2/07, 72 FR 9441.	
5–40–7920	Registration	4/1/96 10/4/06	3/2/07, 72 FR 9441.	

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State citation	Title/subject	State effective date	EPA approval date	Explanation [former SIP citation]
5–40–7930	Facility and Control Equipment Maintenance and Malfunction.	4/1/96 10/4/06	3/2/07, 72 FR 9441.	
5–40–7940	Permits	4/1/96 10/4/06	3/2/07, 72 FR 9441.	
9 VAC 5, Chapter 50 New and Modified Stationary Sources [Part V]				
Part I Special Provisions				
5–50–10	Applicability	8/1/02	3/15/04, 69 FR 12074.	
5–50–20	Compliance	8/1/02	3/15/04, 69 FR 12074.	
5–50–30	Performance Testing	8/1/02	3/15/04, 69 FR 12074.	
5–50–40	Monitoring	8/1/02	3/15/04, 69 FR 12074.	
5–50–50	Notification, Records and Reporting	8/1/02	3/15/04, 69 FR 12074.	
Part II Emission Standards				
Article 1 Standards of Performance for Visible Emissions and Fugitive Dust/Emissions (Rule 5–1)				
5–50–60	Applicability and Designation of Affected Facility.	4/17/95	4/21/00, 65 FR 21315	120–05–0101.
5–50–70	Definitions	4/17/95	4/21/00, 65 FR 21315	120–05–0102.
5–50–80	Standard for Visible Emissions	4/17/95	4/21/00, 65 FR 21315	120–05–0103.
5–50–90	Standard for Fugitive Dust/Emissions	2/1/03	4/29/05, 70 FR 22263.	
5–50–100	Monitoring	4/17/95	4/21/00, 65 FR 21315	120–05–0105.
5–50–110	Test Methods and Procedures	4/17/95	4/21/00, 65 FR 21315	120–05–0106.
5–50–120	Waivers	2/1/03	4/29/05, 70 FR 22263.	
Article 4 Standards of Performance for Stationary Sources (Rule 5–4)				
5–50–240	Applicability and Designation of Affected Facility.	4/17/95	4/21/00, 65 FR 21315	120–05–0401.
5–50–250	Definitions	9/1/06	10/22/08, 73 FR 62897	Revised definition of New Source Review Program, Limited Approval.
5–50–260	Standard for Stationary Sources	4/17/95	4/21/00, 65 FR 21315	120–05–0403.
5–50–270	Standard for Major Stationary Sources (Nonattainment Areas).	9/1/06	10/22/08, 73 FR 62893	Changes Qualifying pollutant to Regulated NSR pollutant, Limited Approval.
5–50–280	Standard for Major Stationary Sources (Prevention of Significant Deterioration Areas).	9/1/06	10/22/08, 73 FR 62897	Changes Pollutant subject to regulation under the Federal Clean Air Act to Regulated NSR pollutant, Limited Approval.
5–50–290	Standard for Visible Emissions	4/17/95	4/21/00, 65 FR 21315	120–05–0406.
5–50–300	Standard for Fugitive Dust/Emissions	4/17/95	4/21/00, 65 FR 21315	120–05–0407.
5–50–330	Compliance	4/17/95	4/21/00, 65 FR 21315	120–05–0410.
5–50–340	Test Methods and Procedures	4/17/95	4/21/00, 65 FR 21315	120–05–0411.
5–50–350	Monitoring	4/17/95	4/21/00, 65 FR 21315	120–05–0412.
5–50–360	Notification, Records and Reporting	4/17/95	4/21/00, 65 FR 21315	120–05–0413.
5–50–370	Registration	4/17/95	4/21/00, 65 FR 21315	120–05–0414.
5–50–380	Facility and Control Equipment Maintenance or Malfunction.	4/17/95	4/21/00, 65 FR 21315	120–05–0415.
5–50–390	Permits	4/17/95	4/21/00, 65 FR 21315	120–05–0416.
9 VAC 5, Chapter 70 Air Pollution Episode Prevention [Part VII]				
5–70–10	Applicability	4/17/95	4/21/00, 65 FR 21315	120–07–01.
5–70–20	Definitions	4/17/95	4/21/00, 65 FR 21315	120–07–02.
5–70–30	General	4/17/95	4/21/00, 65 FR 21315	120–07–03.
5–70–40	Episode Determination	4/1/99	10/19/0065 FR 62626	References to TSP have been removed.
5–70–50	Standby Emission Reduction Plans	4/17/95	4/21/00, 65 FR 21315	120–07–05.
5–70–60	Control Requirements	4/17/95	4/21/00, 65 FR 21315	120–07–06.
5–70–70	Local Air Pollution Control Agency Participation.	4/17/95	4/21/00, 65 FR 21315	120–07–07.
9 VAC 5, Chapter 80 Permits for Stationary Sources [Part VIII]				
5–80–10	New and Modified Stationary Sources	4/17/95	4/21/00, 65 FR 21315	120–08–01.
10A	Applicability	4/17/95	4/21/00, 65 FR 21315	01A.
10B	Definitions	4/17/95	4/21/00, 65 FR 21315	01B.
10C (Exc.C1.b)	General	4/17/95	4/21/00, 65 FR 21315	01C. (Exc.C.1.b)

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State citation	Title/subject	State effective date	EPA approval date	Explanation [former SIP citation]
10D	Applications	4/17/95	4/21/00, 65 FR 21315	01D.
10E.	Information required	4/17/95	4/21/00, 65 FR 21315	01E.
10F	Action on permit application	4/17/95	4/21/00, 65 FR 21315	01F.
10G	Public participation	4/17/95	4/21/00, 65 FR 21315	01G.; Exceptions: 10.G.1 and 10G.4.b.
VR120–08–01C.4.b., c.	Public Participation—public hearing requirements for major modifications.	7/31/81; recodified 2/1/85	5/4/82, 47 FR 19134; recodified 2/25/93, 58 FR 11373.	*See* § 52.2423(o).
10H.2. and 10H.3	Standards for granting permits	4/17/95	4/21/00, 65 FR 21315	01H.2. and 01H.3.
10I.1. and 10I.3	Application review and analysis	4/17/95	4/21/00, 65 FR 21315	01I.1. and 01I.3.
10J	Compliance determination and verification by performance testing.	4/17/95	4/21/00, 65 FR 21315	01J.
10K	Permit invalidation, revocation and enforcement.	4/17/95	4/21/00, 65 FR 21315	01K.
10L	Existence of permit no defense	4/17/95	4/21/00, 65 FR 21315	01L.
10M	Compliance with local zoning requirements.	4/17/95	4/21/00, 65 FR 21315	01M.
10N	Reactivation and permanent shutdown	4/17/95	4/21/00, 65 FR 21315	01N.
10O	Transfer of permits	4/17/95	4/21/00, 65 FR 21315	01O.
10P	Circumvention	4/17/95	4/21/00, 65 FR 21315	01P.
5–80–11	Stationary source permit exemption levels.	7/1/97	4/21/00, 65 FR 21315	Appendix R.
Article 5 State Operating Permits				
5–80–800	Applicability	4/1/98	6/27/03, 68 FR 38191.	
5–80–810	Definitions	4/1/98	6/27/03, 68 FR 38191.	
5–80–820	General	4/1/98	6/27/03, 68 FR 38191.	
5–80–830	Applications	4/1/98	6/27/03, 68 FR 38191.	
5–80–840	Application information required	4/1/98	6/27/03, 68 FR 38191.	
5–80–850	Standards and conditions for granting Permits.	4/1/98	6/27/03, 68 FR 38191.	
5–80–860	Action on permit application	4/1/98	6/27/03, 68 FR 38191.	
5–80–870	Application review and analysis	4/1/98	6/27/03, 68 FR 38191.	
5–80–880	Compliance determination and verification by testing.	4/1/98	6/27/03, 68 FR 38191.	
5–80–890	Monitoring requirements	4/1/98	6/27/03, 68 FR 38191.	
5–80–900	Reporting requirements	4/1/98	6/27/03, 68 FR 38191.	
5–80–910	Existence of permits no defense	4/1/98	6/27/03, 68 FR 38191.	
5–80–920	Circumvention	4/1/98	6/27/03, 68 FR 38191.	
5–80–930	Compliance with local zoning requirements.	4/1/98	6/27/03, 68 FR 38191.	
5–80–940	Transfer of Permits	4/1/98	6/27/03, 68 FR 38191.	
5–80–950	Termination of Permits	4/1/98	6/27/03, 68 FR 38191.	
5–80–960	Changes to Permits	4/1/98	6/27/03, 68 FR 38191.	
5–80–970	Administrative permit amendments	4/1/98	6/27/03, 68 FR 38191.	
5–80–980	Minor permit amendments	4/1/98	6/27/03, 68 FR 38191.	
5–80–990	Significant permit amendments	4/1/98	6/27/03, 68 FR 38191.	
5–80–1000	Reopening for cause	4/1/98	6/27/03, 68 FR 38191.	
5–80–1010	Enforcement	4/1/98	6/27/03, 68 FR 38191.	
5–80–1020	Public participation	4/1/98	6/27/03, 68 FR 38191.	
5–80–1030	General Permits	4/1/98	6/27/03, 68 FR 38191.	
5–80–1040	Review and evaluation of article	4/1/98	6/27/03, 68 FR 38191.	
Article 8 Permits—Major Stationary Sources and Major Modifications Located in Prevention of Significant Deterioration Areas				
5–80–1605	Applicability	9/1/06	10/22/08, 73 FR 62897	5–80–1700, Limited Approval.
5–80–1615	Definitions	9/1/06	10/22/08, 73 FR 62897	5–80–1710, Limited Approval.
5–80–1625	General	9/1/06	10/22/08, 73 FR 62897	5–80–1720, Limited Approval.
5–80–1635	Ambient Air Increments	9/1/06	10/22/08, 73 FR 62897	5–80–1730, Limited Approval.
5–80–1645	Ambient Air Ceilings	9/1/06	10/22/08, 73 FR 62897	5–80–1740, Limited Approval.
5–80–1655	Applications	9/1/06	10/22/08, 73 FR 62897	5–80–1750, Limited Approval.
5–80–1665	Compliance with local zoning requirements.	9/1/06	10/22/08, 73 FR 62897	5–80–1760, Limited Approval.
5–80–1675	Compliance determination and verification by performance testing.	9/1/06	10/22/08, 73 FR 62897	5–80–1770, Limited Approval.
5–80–1685	Stack Heights	9/1/06	10/22/08, 73 FR 62897	5–80–1780, Limited Approval.
5–80–1695	Exemptions	9/1/06	10/22/08, 73 FR 62897	New, Limited Approval.
5–80–1705	Control technology review	9/1/06	10/22/08, 73 FR 62897	5–80–1800, Limited Approval.
5–80–1715	Source impact analysis	9/1/06	10/22/08, 73 FR 62897	5–80–1810 Limited Approval.

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State citation	Title/subject	State effective date	EPA approval date	Explanation [former SIP citation]
5–80–1725	Air quality models	9/1/06	10/22/08, 73 FR 62897	5–80–1820, Limited Approval.
5–80–1735	Air quality analysis	9/1/06	10/22/08, 73 FR 62897	5–80–1830, Limited Approval.
5–80–1745	Source Information	9/1/06	10/22/08, 73 FR 62897	5–80–1840, Limited Approval.
5–80–1755	Additional impact analysis	9/1/06	10/22/08, 73 FR 62897	5–80–1850, Limited Approval.
5–80–1765	Sources affecting Federal class I areas—additional requirements.	9/1/06	10/22/08, 73 FR 62897	5–80–1860, Limited Approval.
5–80–1775	Public participation	9/1/06	10/22/08, 73 FR 62897	5–80–1870, Limited Approval.
5–80–1785	Source obligation	9/1/06	10/22/08, 73 FR 62897	5–80–1880, Limited Approval.
5–80–1795	Environmental impact statements	9/1/06	10/22/08, 73 FR 62897	5–80–1890, Limited Approval.
5–80–1805	Disputed permits	9/1/06	10/22/08, 73 FR 62897	5–80–1900, Limited Approval.
5–80–1815	Interstate pollution abatement	9/1/06	10/22/08, 73 FR 62897	5–80–1910, Limited Approval.
5–80–1825	Innovative control technology	9/1/06	10/22/08, 73 FR 62897	5–80–1920, Limited Approval.
5–80–1835	Reserved	9/1/06	10/22/08, 73 FR 62897	New, Limited Approval.
5–80–1845	Reserved	9/1/06	10/22/08, 73 FR 62897	New, Limited Approval.
5–80–1855	Reserved	9/1/06	10/22/08, 73 FR 62897	New, Limited Approval.
5–80–1865	Actuals plantwide applicability (PAL)	9/1/06	10/22/08, 73 FR 62897	New, Limited Approval.
5–80–1925	Changes to permits	9/1/06	10/22/08, 73 FR 62897	New, Limited Approval.
5–80–1935	Administrative permit amendments	9/1/06	10/22/08, 73 FR 62897	New, Limited Approval.
5–80–1945	Minor permit amendments	9/1/06	10/22/08, 73 FR 62897	New, Limited Approval.
5–80–1955	Significant amendment procedures	9/1/06	10/22/08, 73 FR 62897	New, Limited Approval.
5–80–1965	Reopening for cause	9/1/06	10/22/08, 73 FR 62897	New, Limited Approval.
5–80–1975	Transfer of permits	9/1/06	10/22/08, 73 FR 62897	5–80–1940, Limited Approval.
5–80–1985	Permit invalidation, revocation, and enforcement.	9/1/06	10/22/08, 73 FR 62897	5–80–1950, Limited Approval.
5–80–1995	Existence of permit no defense	9/1/06	10/22/08, 73 FR 62897	New, Limited Approval.
Article 9 Permits—Major Stationary Sources and Major Modifications Located in Nonattainment Areas or the Ozone Transport Region				
5–80–2000	Applicability	5/1/02 9/1/06	10/22/08, 73 FR 62893	Limited Approval of 9/1/06 amendments.
5–80–2010	Definitions	5/1/02 9/1/06	10/22/08, 73 FR 62893	Limited Approval of 9/1/06 amendments.
5–80–2020	General	5/1/02 9/1/06	10/22/08, 73 FR 62893	Limited Approval of 9/1/06 amendments.
5–80–2030	Applications	5/1/02 9/1/06	10/22/08, 73 FR 62893	Limited Approval of 9/1/06 amendments.
5–80–2040	Application information required	5/1/02 9/1/06	10/22/08, 73 FR 62893	Limited Approval of 9/1/06 amendments.
5–80–2050	Standards and conditions for granting permits.	5/1/02 9/1/06	10/22/08, 73 FR 62893	Limited Approval of 9/1/06 amendments.
5–80–2060	Action on permit applications	5/1/02 9/1/06	10/22/08, 73 FR 62893	Limited Approval of 9/1/06 amendments.
5–80–2070	Public participation	5/1/02 9/1/06	10/22/08, 73 FR 62893	Limited Approval of 9/1/06 amendments.
5–80–2080	Compliance determination and verification by performance testing.	5/1/02 9/1/06	10/22/08, 73 FR 62893	Limited Approval of 9/1/06 amendments.
5–80–2090	Application review and analysis	5/1/02 9/1/06	10/22/08, 73 FR 62893	Limited Approval of 9/1/06 amendments.
5–80–2091	Source Obligation	9/1/06	10/22/08, 73 FR 62893	New, Limited Approval.
5–80–2110	Interstate Pollution Abatement	5/1/02 9/1/06	10/22/08, 73 FR 62893	Limited Approval of 9/1/06 amendments.
5–80–2120	Offsets	5/1/02 9/1/06	10/22/08, 73 FR 62893	Limited Approval of 9/1/06 amendments.
5–80–2130	De minimis increases and stationary source modification alternatives for ozone nonattainment areas classified as serious or severe in 9 VAC 5–20–204.	5/1/02 9/1/06	10/22/08, 73 FR 62893	Limited Approval of 9/1/06 amendments.
5–80–2140	Exception	5/1/02 9/1/06	10/22/08, 73 FR 62893	Limited Approval of 9/1/06 amendments.
5–80–2144	Actuals plantwide applicability limits (PALs).	9/1/06	10/22/08, 73 FR 62893	New, Limited Approval.
5–80–2150	Compliance with local zoning requirements.	5/1/02 9/1/06	10/22/08, 73 FR 62893	Limited Approval of 9/1/06 amendments.
5–80–2170	Transfer of permits	5/1/02 9/1/06	10/22/08, 73 FR 62893	Limited Approval of 9/1/06 amendments.
5–80–2180	Permit invalidation, revocation and enforcement.	5/1/02 9/1/06	10/22/08, 73 FR 62893	Limited Approval of 9/1/06 amendments.

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5–80–2190	Existence of permit no defense	5/1/02 9/1/06	10/22/08, 73 FR 62893	Limited Approval of 9/1/06 amendments.
5–80–2200	Changes to permits	5/1/02 9/1/06	10/22/08, 73 FR 62893	New, Limited Approval of 9/1/06 amendments.
5–80–2210	Administrative permit amendments	5/1/02 9/1/06	10/22/08, 73 FR 62893	New, Limited Approval of 9/1/06 amendments.
5–80–2220	Minor permit amendments	5/1/02 9/1/06	10/22/08, 73 FR 62893	New, Limited Approval of 9/1/06 amendments.
5–80–2230	Significant amendment procedures	5/1/02 9/1/06	10/22/08, 73 FR 62893	New, Limited Approval of 9/1/06 amendments.
5–80–2240	Reopening for cause	5/1/02 9/1/06	10/22/08, 73 FR 62893	New, Limited Approval of 9/1/06 amendments.
9 VAC 5, Chapter 91 Regulations for the Control of Motor Vehicle Emissions in the Northern Virginia Area				
		Part I Definitions		
5–91–10	General	1/24/97	9/1/99, 64 FR 47670.	
5–91–20	Terms defined	1/24/97 6/29/05	9/1/99, 64 FR 47670 4/22/08, 73 FR 21540.	Exception—"Northern Virginia program area" does not include Fauquier County, Effective 1/1/98.
		Part II General Provisions		
5–91–30	Applicability and authority of the department.	10/1/02	4/22/08, 73 FR 21540.	
5–91–40	Establishment of Regulations and Orders.	1/24/97	9/1/99, 64 FR 47670.	
5–91–50	Documents incorporated by reference	10/1/02	4/22/08, 73 FR 21540.	
5–91–60	Hearings and Proceedings	1/24/97	9/1/99, 64 FR 47670.	
5–91–70	Appeal of case decisions	10/1/02	4/22/08, 73 FR 21540.	
5–91–80	Variances	1/24/97	9/1/99, 64 FR 47670.	
5–91–90	Right of entry	1/24/97	9/1/99, 64 FR 47670.	
5–91–100	Conditions on approvals	1/24/97	9/1/99, 64 FR 47670.	
5–91–110	Procedural information and guidance	1/24/97	9/1/99, 64 FR 47670.	
5–91–120	Export and import of motor vehicles	10/1/02	4/22/08, 73 FR 21540.	
5–91–130	Relationship of state regulations to Federal regulations.	1/24/97	9/1/99, 64 FR 47670.	
5–91–140	Delegation of authority	1/24/97	9/1/99, 64 FR 47670.	
5–91–150	Availability of information	1/24/97	9/1/99, 64 FR 47670.	
		Part III Emission Standards for Motor Vehicle Air Pollution		
5–91–160	Exhaust emission standards for two-speed idle testing in enhanced emissions inspection programs.	6/29/05	4/22/08, 73 FR 21540.	
5–91–170	Exhaust emission standards for ASM testing in enhanced emissions inspection programs.	10/1/02	4/22/08, 73 FR 21540.	
5–91–180	Exhaust emission standards for on-road testing through remote sensing.	6/29/05	4/22/08, 73 FR 21540.	
5–91–190	Emissions control system standards	10/1/02	4/22/08, 73 FR 21540.	
5–91–200	Evaporative emissions standards	10/1/02	4/22/08, 73 FR 21540.	
5–91–210	Visible emissions standards	10/1/02	4/22/08, 73 FR 21540.	
		Part IV Permitting and Operation of Emissions Inspection Stations		
5–91–220	General provisions	10/1/02	4/22/08, 73 FR 21540.	
5–91–230	Applications	10/1/02	4/22/08, 73 FR 21540.	
5–91–240	Standards and conditions for permits	1/27/97	9/1/99, 64 FR 47670.	
5–91–250	Action on permit application	1/27/97	9/1/99, 64 FR 47670.	
5–91–260	Emissions inspection station permits, categories.	10/1/02	4/22/08, 73 FR 21540.	
5–91–270	Permit renewals	10/1/02	4/22/08, 73 FR 21540.	
5–91–280	Permit revocation, surrender of materials.	1/24/97	9/1/99, 64 FR 47670.	
5–91–290	Emissions inspection station operations.	10/1/02	4/22/08, 73 FR 21540.	
5–91–300	Emissions inspection station records	10/1/02	4/22/08, 73 FR 21540.	

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State citation	Title/subject	State effective date	EPA approval date	Explanation [former SIP citation]
5–91–310	Sign and permit posting	10/1/02	4/22/08, 73 FR 21540.	
5–91–320	Equipment and facility requirements	10/1/02	4/22/08, 73 FR 21540.	
5–91–330	Analyzer system operation	10/1/02	4/22/08, 73 FR 21540.	
5–91–340	Motor vehicle inspection report; certificate of emissions inspection.	10/1/02	4/22/08, 73 FR 21540.	
5–91–350	Data media	1/24/97	9/1/99, 64 FR 47670.	
5–91–360	Inspector identification number and access code usage.	10/1/02	4/22/08, 73 FR 21540	Retitled and amended.
5–91–370	Fleet emissions inspection stations; mobile fleet inspection stations.	10/1/02	4/22/08, 73 FR 21540.	
Part V Emissions Inspector Testing and Licensing				
5–91–380	Emissions inspector licenses and renewals.	10/21/02	4/22/08, 73 FR 21540.	
5–91–390	Qualification requirements for emissions inspector licenses.	1/24/97	9/1/99, 64 FR 47670.	
5–91–400	Conduct of emissions inspectors	1/24/97	9/1/99, 64 FR 47670.	
Part VI Inspection Procedures				
5–91–410	General	10/1/02	4/22/08, 73 FR 21540.	
5–91–420	Inspection procedure; rejection, pass, fail, waiver.	10/1/02	4/22/08, 73 FR 21540.	
5–91–430	ASM test procedure	10/1/02	4/22/08, 73 FR 21540.	
5–91–440	Two-speed idle test procedure	10/1/02	4/22/08, 73 FR 21540.	
5–91–450	Evaporative system pressure test and gas cap pressure test procedure.	10/1/02	4/22/08, 73 FR 21540	Retitled and amended.
5–91–480	Emissions related repairs	10/1/02	4/22/08, 73 FR 21540.	
5–91–490	Engine and fuel changes	10/1/02	4/22/08, 73 FR 21540.	
Part VII Vehicle Emissions Repair Facility Certification				
5–91–500	Applicability and authority	10/1/02	4/22/08, 73 FR 21540.	
5–90–510	Certification qualifications	10/1/02	4/22/08, 73 FR 21540.	
5–91–520	Expiration, reinstatement, renewal, and requalification.	10/1/02	4/22/08, 73 FR 21540.	
5–91–530	Emissions and repair facility operations.	10/1/02	4/22/08, 73 FR 21540.	
5–91–540	Sign and certificate posting	10/1/02	4/22/08, 73 FR 21540	Retitled and amended.
Part VIII Emissions Repair Technician Certification and Responsibilities				
5–91–550	Applicability and authority	10/1/02	4/22/08, 73 FR 21540.	
5–91–560	Certification qualifications for emissions repair technicians.	10/1/02	4/22/08, 73 FR 21540.	
5–91–570	Expiration, reinstatement, renewal and requalification.	10/1/02	4/22/08, 73 FR 21540.	
5–91–580	Certified emissions repair technician responsibilities.	10/1/02	4/22/08, 73 FR 21540.	
Part IX Enforcement Procedures				
5–91–590	Enforcement of regulations, permits, licenses, certifications and orders.	10/1/02	4/22/08, 73 FR 21540.	
5–91–600	General enforcement process	10/1/02	4/22/08, 73 FR 21540.	
5–91–610	Consent orders and penalties for violations.	10/1/02	4/22/08, 73 FR 21540.	
5–91–620	Major violations	10/1/02	4/22/08, 73 FR 21540.	
5–91–630	Minor violations	4/2/97	9/1/99, 64 FR 47670.	
Part X Analyzer System Certification and Specifications for Enhanced Emissions Inspections Programs				
5–91–640	Applicability	1/24/97	9/1/99, 64 FR 47670.	
5–91–650	Design goals	10/1/02	4/22/08, 73 FR 21540.	
5–91–660	Warranty; service contract	10/1/02	4/22/08, 73 FR 21540.	
5–91–670	Owner-provided services	10/1/02	4/22/08, 73 FR 21540.	
5–91–680	Certification of analyzer systems	10/1/02	4/22/08, 73 FR 21540.	
5–91–690	Span gases; gases for calibration purposes.	10/1/02	4/22/08, 73 FR 21540.	
5–91–700	Calibration of exhaust gas analyzers	10/1/02	4/22/08, 73 FR 21540.	

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5–91–710	Upgrade of analyzer system	10/1/02	4/22/08, 73 FR 21540.	
Part XI Manufacturer Recall				
5–91–720	Vehicle manufacturers recall	10/1/02	4/22/08, 73 FR 21540.	
5–91–730	Exemptions; temporary extensions	1/24/97	9/1/99, 64 FR 47670.	
Part XII On-Road Testing				
5–91–740	General requirements	6/29/05	4/22/08, 73 FR 21540.	
5–91–750	Operating procedures; violation of standards.	6/29/05	4/22/08, 73 FR 21540.	
5–91–760	Schedule of civil charges	6/29/05	4/22/08, 73 FR 21540.	
Part XIV ASM Exhaust Emission Standards				
5–91–790	ASM start-up standards	10/1/02	4/22/08, 73 FR 21540.	
5–91–800	ASM final standards	10/1/02	4/22/08, 73 FR 21540.	
9 VAC 5, Chapter 140 Regulation for Emissions Trading				
Part I NO_X Budget Trading Program				
Article 1 NO_X Budget Trading Program General Provisions				
5–140–10	Purpose	7/17/02	7/8/03, 68 FR 40520.	
5–140–20	Definitions	7/17/02	7/8/03, 68 FR 40520.	
5–140–30	Measurements, abbreviations, and acronyms.	7/17/02	7/8/03, 68 FR 40520.	
5–140–31	Federal Regulations Incorporated by reference.	7/17/02	7/8/03, 68 FR 40520.	
5–140–40	Applicability	7/17/02	7/8/03, 68 FR 40520.	
5–140–50	Retired unit exemption	7/17/02	7/8/03, 68 FR 40520.	
5–140–60	Standard requirements	7/17/02	7/8/03, 68 FR 40520.	
5–140–70	Computation of time	7/17/02	7/8/03, 68 FR 40520.	
Article 2 NO_X Authorized Account Representative for NO_X Budget Sources				
5–140–100	Authorization and responsibilities of the NO_X authorized account representative.	7/17/02	7/8/03, 68 FR 40520.	
5–140–110	Alternate NO_X authorized account representative.	7/17/02	7/8/03, 68 FR 40520.	
5–140–120	Changing the NO_X authorized account representative and alternate NO_X authorized account representative; changes in the owners and operators.	7/17/02	7/8/03, 68 FR 40520.	
5–140–130	Account certificate of representation	7/17/02	7/8/03, 68 FR 40520.	
5–140–140	Objections concerning the NO_X authorized account representative.	7/17/02	7/8/03, 68 FR 40520.	
Article 3 Permits				
5–140–200	General NO_X Budget permit requirements.	7/17/02	7/8/03, 68 FR 40520.	
5–140–210	Submission of NO_X Budget permit applications.	7/17/02	7/8/03, 68 FR 40520.	
5–140–220	Information requirements for NO_X Budget permit applications.	7/17/02	7/8/03, 68 FR 40520.	
5–140–230	NO_X Budget permit contents	7/17/02	7/8/03, 68 FR 40520.	
5–140–240	Effective date of initial NO_X Budget permit.	7/17/02	7/8/03, 68 FR 40520.	
5–140–250	NO_X Budget permit revisions	7/17/02	7/8/03, 68 FR 40520.	
Article 4 Compliance Certification				
5–140–300	Compliance certification report	7/17/02	7/8/03, 68 FR 40520.	

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5–140–310	Permitting authority's and administrator's actionon compliance certifications.	7/17/02	7/8/03, 68 FR 40520.	
Article 5 NO_X Allowance Allocations				
5–140–400	State trading program budget	7/17/02	7/8/03, 68 FR 40520.	
5–140–410	Timing requirements for NO_X allowance allocations.	7/17/02	7/8/03, 68 FR 40520.	
5–140–420	NO_X allowance allocations	7/17/02	7/8/03, 68 FR 40520.	
5–140–430	Compliance Supplement Pool	7/17/02	7/8/03, 68 FR 40520.	
Article 6 NO_X Allowance Tracking System				
5–140–500	NO_X Allowance Tracking System accounts.	7/17/02	7/8/03, 68 FR 40520.	
5–140–510	Establishment of accounts	7/17/02	7/8/03, 68 FR 40520.	
5–140–520	NO_X Allowance Tracking System responsibilities of NO_X authorized account representative.	7/17/02	7/8/03, 68 FR 40520.	
5–140–530	Recordation of NO_X allowance allocations.	7/17/02	7/8/03, 68 FR 40520.	
5–140–540	Compliance	7/17/02	7/8/03, 68 FR 40520.	
5–140–550	Banking	3/24/04	8/25/04, 69 FR 52174.	
5–140–560	Account error	7/17/02	7/8/03, 68 FR 40520.	
5–140–570	Closing of general accounts	7/17/02	7/8/03, 68 FR 40520.	
Article 7 NO_X Allowance Transfers				
5–140–600	Scope and submission of NO_X allowance transfers.	7/17/02	7/8/03, 68 FR 40520.	
5–140–610	EPA recordation	7/17/02	7/8/03, 68 FR 40520.	
5–140–620	Notification	7/17/02	7/8/03, 68 FR 40520.	
Article 8 Monitoring and Reporting				
5–140–700	General Requirements	7/17/02	7/8/03, 68 FR 40520.	
5–140–710	Initial certification and recertification procedures.	7/17/02	7/8/03, 68 FR 40520.	
5–140–720	Out of control periods	7/17/02	7/8/03, 68 FR 40520.	
5–140–730	Notifications	7/17/02	7/8/03, 68 FR 40520.	
5–140–740	Recordkeeping and reporting	7/17/02	7/8/03, 68 FR 40520.	
5–140–750	Petitions.	7/17/02	7/8/03, 68 FR 40520.	
5–140–760	Additional requirements to provide heat input data for allocation purposes.	7/17/02	7/8/03, 68 FR 40520.	
Article 9 Individual Unit Opt-ins				
5–140–800	Applicability	7/17/02	7/8/03, 68 FR 40520.	
5–140–810	General	7/17/02	7/8/03, 68 FR 40520.	
5–140–820	NO_X authorized account representative.	7/17/02	7/8/03, 68 FR 40520.	
5–140–830	Applying for NO_X Budget opt-in permit	7/17/02	7/8/03, 68 FR 40520.	
5–140–840	Opt-in process	7/17/02	7/8/03, 68 FR 40520.	
5–140–850	NO_X Budget opt-in permit contents	7/17/02	7/8/03, 68 FR 40520.	
5–140–860	Withdrawal from NO_X Budget Trading Program.	7/17/02	7/8/03, 68 FR 40520.	
5–140–870	Change in regulatory status	7/17/02	7/8/03, 68 FR 40520.	
5–140–880	NO_X allowance allocations to opt-in units.	7/17/02	7/8/03, 68 FR 40520.	
Article 10 State Trading Program Budget and Compliance Pool				
5–140–900	State trading program budget	7/17/02	7/8/03, 68 FR 40520.	
5–140–910	Compliance supplement pool budget	7/17/02	7/8/03, 68 FR 40520.	
5–140–920	Total electric generating unit allocations.	7/17/02	7/8/03, 68 FR 40520.	
5–140–930	Total non-electric generating unit allocations.	7/17/02	7/8/03, 68 FR 40520.	

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Part II NO_X Annual Trading Program				
Article 1 CAIR NO_X Annual Trading Program General Provisions				
5–140–1010	Purpose	4/18/07	12/28/07, 72 FR 73602.	
5–140–1020	Definitions	4/18/07	12/28/07, 72 FR 73602	Except for definition of Nonattainment condition.
5–140–1030	Measurements, abbreviations, and acronyms.	4/18/07	12/28/07, 72 FR 73602.	
5–140–1040	Applicability	4/18/07	12/28/07, 72 FR 73602.	
5–140–1050	Retired Unit Exemption	4/18/07	12/28/07, 72 FR 73602.	
5–140–1060	Standard requirements	4/18/07	12/28/07, 72 FR 73602.	
5–140–1070	Computation of time	4/18/07	12/28/07, 72 FR 73602.	
5–140–1080	Appeal procedures	4/18/07	12/28/07, 72 FR 73602.	
Article 2 CAIR-designated Representative for CAIR NO_X Sources				
5–140–1100	Authorization and responsibilities of CAIR-designated representative.	4/18/07	12/28/07, 72 FR 73602.	
5–140–1110	Alternate CAIR-designated representative.	4/18/07	12/28/07, 72 FR 73602.	
5–140–1120	Changing CAIR-designated representative and alternate CAIR-designated representative; changes in owners and operators.	4/18/07	12/28/07, 72 FR 73602.	
5–140–1130	Certificate of representation	4/18/07	12/28/07, 72 FR 73602.	
5–140–1140	Objections concerning CAIR-designated representative.	4/18/07	12/28/07, 72 FR 73602.	
5–140–1150	Delegation by CAIR-designated representative and alternate CAIR-designated representative.	4/18/07		
Article 3 Permits				
5–140–1200	General CAIR NO_X Annual Trading Program permit requirements.	4/18/07	12/28/07, 72 FR 73602.	
5–140–1210	Submission of CAIR permit applications.	4/18/07	12/28/07, 72 FR 73602.	
5–140–1220	Information requirements for CAIR permit applications.	4/18/07	12/28/07, 72 FR 73602.	
5–140–1230	CAIR permit contents and term	4/18/07	12/28/07, 72 FR 73602.	
5–140–1240	CAIR permit revisions	4/18/07	12/28/07, 72 FR 73602.	
Article 5 CAIR NO_X Allowance Allocations				
5–140–1400	CAIR NO_X Annual trading budgets	4/18/07	12/28/07, 72 FR 73602.	
5–140–1410	Timing requirements for CAIR NO_X allowance allocations.	4/18/07	12/28/07, 72 FR 73602.	
5–140–1420	CAIR NO_X allowance allocations	4/18/07	12/28/07, 72 FR 73602.	
5–140–1430	Compliance supplement pool	4/18/07	12/28/07, 72 FR 73602.	
Article 6 CAIR NO_X Allowance Tracking System				
5–140–1510	Establishment of accounts	4/18/07	12/28/07, 72 FR 73602.	
5–140–1520	Responsibilities of CAIR-authorized account representative.	4/18/07	12/28/07, 72 FR 73602.	
5–140–1530	Recordation of CAIR NO_X allowance allocations.	4/18/07	12/28/07, 72 FR 73602.	
5–140–1540	Compliance with CAIR NO_X emissions limitation.	4/18/07	12/28/07, 72 FR 73602.	
5–140–1550	Banking	4/18/07	12/28/07, 72 FR 73602.	
5–140–1560	Account error	4/18/07	12/28/07, 72 FR 73602.	
5–140–1570	Closing of general accounts	4/18/07	12/28/07, 72 FR 73602.	
Article 7 CAIR NO_X Allowance Transfers				
5–140–1600	Submission of CAIR NO_X allowance transfers.	4/18/07	12/28/07, 72 FR 73602.	
5–140–1610	EPA recordation	4/18/07	12/28/07, 72 FR 73602.	
5–140–1620	Notification	4/18/07	12/28/07, 72 FR 73602.	

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Article 8 Monitoring and Reporting				
5–140–1700	General requirements	4/18/07	12/28/07, 72 FR 73602.	
5–140–1710	Initial certification and recertification procedures.	4/18/07	12/28/07, 72 FR 73602.	
5–140–1720	Out of control periods	4/18/07	12/28/07, 72 FR 73602.	
5–140–1730	Notifications	4/18/07	12/28/07, 72 FR 73602.	
5–140–1740	Recordkeeping and reporting	4/18/07	12/28/07, 72 FR 73602.	
5–140–1750	Petitions	4/18/07	12/28/07, 72 FR 73602.	
Article 9 CAIR NO_X Opt-in Units				
5–140–1800	Applicability		4/18/07	12/28/07, 72 FR 73602
5–140–1810	General	4/18/07	12/28/07, 72 FR 73602.	
5–140–1820	CAIR-designated representative	4/18/07	12/28/07, 72 FR 73602.	
5–140–1830	Applying for CAIR opt-in permit	4/18/07	12/28/07, 72 FR 73602.	
5–140–1840	Opt-in process	4/18/07	12/28/07, 72 FR 73602.	
5–140–1850	CAIR opt-in permit content	4/18/07	12/28/07, 72 FR 73602.	
5–140–1860	Withdrawal from CAIR NO_X Annual Trading Program.	4/18/07	12/28/07, 72 FR 73602.	
5–140–1870	Change in regulatory status	4/18/07	12/28/07, 72 FR 73602.	
5–140–1880	CAIR NO_X allowance allocations to CAIR NO_X opt-in units.	4/18/07	12/28/07, 72 FR 73602.	
Part III NO_X Ozone Season Trading Program				
Article 1 CAIR NO_X Ozone Season Trading Program General Provisions				
5–140–2010	Purpose	4/18/07	12/28/07, 72 FR 73602.	
5–140–2020	Definitions	4/18/07	12/28/07, 72 FR 73602	Except for definition of Nonattainment condition.
5–140–2030	Measurements, abbreviations, and acronyms.	4/18/07	12/28/07, 72 FR 73602.	
5–140–2040	Applicability	4/18/07	12/28/07, 72 FR 73602.	
5–140–2050	Retired unit exemption	4/18/07	12/28/07, 72 FR 73602.	
5–140–2060	Standard requirements	4/18/07	12/28/07, 72 FR 73602.	
5–140–2070	Computation of time	4/18/07	12/28/07, 72 FR 73602.	
5–140–2080	Appeal procedures	4/18/07	12/28/07, 72 FR 73602.	
Article 2 CAIR-Designated Representative for CAIR NO_X Ozone Season Sources				
5–140–2100	Authorization and responsibilities of CAIR-designated representative.	4/18/07	12/28/07, 72 FR 73602.	
5–140–2110	Alternate CAIR-designated representative.	4/18/07	12/28/07, 72 FR 73602.	
5–140–2120	Changing CAIR-designated representative and alternate CAIR-designated representative; changes in owners and operators.	4/18/07	12/28/07, 72 FR 73602.	
5–140–2130	Certificate of representation	4/18/07	12/28/07, 72 FR 73602.	
5–140–2140	Objections concerning CAIR-designated representative.	4/18/07	12/28/07, 72 FR 73602.	
5–140–2150	Delegation by CAIR-designated representative and alternate CAIR-designated representative.	4/18/07	12/28/07, 72 FR 73602.	
Article 3 Permits				
5–140–2200	General CAIR NO_X Ozone Season Trading Program permit requirements.	4/18/07	12/28/07, 72 FR 73602.	
5–140–2210	Submission of CAIR permit applications.	4/18/07	12/28/07, 72 FR 73602.	
5–140–2220	Information requirements for CAIR permit applications.	4/18/07	12/28/07, 72 FR 73602.	
5–140–2230	CAIR permit contents and term	4/18/07	12/28/07, 72 FR 73602.	
5–140–2240	CAIR permit revisions	4/18/07	12/28/07, 72 FR 73602.	

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Article 5 CAIR NO_X Ozone Season Allowance Allocations				
5–140–2400	CAIR NO_X Ozone Season trading budgets.	4/18/07	12/28/07, 72 FR 73602.	
5–140–2405	State trading budgets for nonelectric generating units.	4/18/07	12/28/07, 72 FR 73602.	
5–140–2410	Timing requirements for CAIR NO_X Ozone Season allowance allocations.	4/18/07	12/28/07, 72 FR 73602.	
5–140–2420	CAIR NO_X Ozone Season allowance allocations.	4/18/07	12/28/07, 72 FR 73602.	
5–140–2430	CAIR NO_X Ozone Season allowance allocations for individual existing nonelectric generating units.	4/18/07	12/28/07, 72 FR 73602.	
Article 6 CAIR NO_X Ozone Season Allowance Tracking System				
5–140–2510	Establishment of accounts	4/18/07	12/28/07, 72 FR 73602.	
5–140–2520	Responsibilities of CAIR-authorized account representative.	4/18/07	12/28/07, 72 FR 73602.	
5–140–2530	Recordation of CAIR NO_X Ozone Season allowance allocations.	4/18/07	12/28/07, 72 FR 73602.	
5–140–2540	Compliance with CAIR NO_X emissions limitation.	4/18/07	12/28/07, 72 FR 73602.	
5–140–2550	Banking	4/18/07	12/28/07, 72 FR 73602.	
5–140–2560	Account error	4/18/07	12/28/07, 72 FR 73602.	
5–140–2570	Closing of general accounts	4/18/07	12/28/07, 72 FR 73602.	
Article 7 CAIR NO_X Ozone Season Allowance Transfers				
5–140–2600	Submission of CAIR NO_X Ozone Season allowance transfers.	4/18/07	12/28/07, 72 FR 73602.	
5–140–2610	EPA recordation	4/18/07	12/28/07, 72 FR 73602.	
5–140–2620	Notification	4/18/07	12/28/07, 72 FR 73602.	
Article 8 Monitoring and Reporting				
5–140–2700	General requirements	4/18/07	12/28/07, 72 FR 73602.	
5–140–2710	Initial certification and recertification procedures.	4/18/07	12/28/07, 72 FR 73602.	
5–140–2720	Out of control periods	4/18/07	12/28/07, 72 FR 73602.	
5–140–2730	Notifications	4/18/07	12/28/07, 72 FR 73602.	
5–140–2740	Recordkeeping and reporting	4/18/07	12/28/07, 72 FR 73602.	
5–140–2750	Petitions	4/18/07	12/28/07, 72 FR 73602.	
Article 9 CAIR NO_X Ozone Season Opt-in Units				
5–140–2800	Applicability	4/18/07	12/28/07, 72 FR 73602.	
5–140–2810	General	4/18/07	12/28/07, 72 FR 73602.	
5–140–2820	CAIR-designated representative	4/18/07	12/28/07, 72 FR 73602.	
5–140–2830	Applying for CAIR opt-in permit	4/18/07	12/28/07, 72 FR 73602.	
5–140–2840	Opt-in process	4/18/07	12/28/07, 72 FR 73602.	
5–140–2850	CAIR opt-in permit contents	4/18/07	12/28/07, 72 FR 73602.	
5–140–2860	Withdrawal from CAIR NO_X Ozone Season Trading Program.	4/18/07	12/28/07, 72 FR 73602.	
5–140–2870	Change in regulatory status	4/18/07	12/28/07, 72 FR 73602.	
5–140–2880	CAIR NO_X Ozone Season allowance allocations to CAIR NO_X Ozone Season opt-in units.	4/18/07	12/28/07, 72 FR 73602.	
Part IV SO_2 Annual Trading Program				
Article 1 CAIR SO_2 Trading Program General Provisions				
5–140–3010	Purpose	4/18/07	12/28/07, 72 FR 73602.	
5–140–3020	Definitions	4/18/07	12/28/07, 72 FR 73602	Except for definition of Nonattainment condition.
5–140–3030	Measurements, abbreviations, and acronyms.	4/18/07	12/28/07, 72 FR 73602.	
5–140–3040	Applicability	4/18/07	12/28/07, 72 FR 73602.	
5–140–3050	Retired Unit Exemption	4/18/07	12/28/07, 72 FR 73602.	

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5–140–3060	Standard requirements	4/18/07	12/28/07, 72 FR 73602.	
5–140–3070	Computation of time	4/18/07	12/28/07, 72 FR 73602.	
5–140–3080	Appeal procedures	4/18/07	12/28/07, 72 FR 73602.	
Article 2 CAIR-designated Representative for CAIR SO_2 Sources				
5–140–3100	Authorization and responsibilities of CAIR-designated representative.	4/18/07	12/28/07, 72 FR 73602.	
5–140–3110	Alternate CAIR-designated representative.	4/18/07	12/28/07, 72 FR 73602.	
5–140–3120	Changing CAIR-designated representative and alternate CAIR-designated representative; changes in owners and operators.	4/18/07	12/28/07, 72 FR 73602.	
5–140–3130	Certificate of representation	4/18/07	12/28/07, 72 FR 73602.	
5–140–3140	Objections concerning CAIR-designated representative.	4/18/07	12/28/07, 72 FR 73602.	
5–140–3150	Delegation by CAIR-designated representative and alternate CAIR-designated representative.	4/18/07	12/28/07, 72 FR 73602.	
Article 3 Permits				
5–140–3200	General CAIR SO_2 Trading Program permit requirements.	4/18/07	12/28/07, 72 FR 73602.	
5–140–3210	Submission of CAIR permit applications.	4/18/07	12/28/07, 72 FR 73602.	
5–140–3220	Information requirements for CAIR permit applications.	4/18/07	12/28/07, 72 FR 73602.	
5–140–3230	CAIR permit contents and term	4/18/07	12/28/07, 72 FR 73602.	
5–140–3240	CAIR permit revisions	4/18/07	12/28/07, 72 FR 73602.	
Article 5 CAIR SO_2 Allowance Allocations				
5–140–3400	State trading budgets	4/18/07	12/28/07, 72 FR 73602.	
5–140–3410	Timing requirements for CAIR SO_2 allowance allocations.	4/18/07	12/28/07, 72 FR 73602.	
5–140–3420	CAIR SO_2 allowance allocations	4/18/07	12/28/07, 72 FR 73602.	
Article 6 CAIR SO_2 Allowance Tracking System				
5–140–3510	Establishment of accounts	4/18/07	12/28/07, 72 FR 73602.	
5–140–3520	Responsibilities of CAIR-authorized account representative.	4/18/07	12/28/07, 72 FR 73602.	
5–140–3530	Recordation of CAIR SO_2 allowances	4/18/07	12/28/07, 72 FR 73602.	
5–140–3540	Compliance with CAIR SO_2 emissions limitation.	4/18/07	12/28/07, 72 FR 73602.	
5–140–3550	Banking	4/18/07	12/28/07, 72 FR 73602.	
5–140–3560	Account error	4/18/07	12/28/07, 72 FR 73602.	
5–140–3570	Closing of general accounts	4/18/07	12/28/07, 72 FR 73602.	
Article 7 CAIR SO_2 Allowance Transfers				
5–140–3600	Submission of CAIR SO_2 allowance transfers.	4/18/07	12/28/07, 72 FR 73602.	
5–140–3610	EPA recordation	4/18/07	12/28/07, 72 FR 73602.	
5–140–3620	Notification	4/18/07	12/28/07, 72 FR 73602.	
Article 8 Monitoring and Reporting				
5–140–3700	General requirements	4/18/07	12/28/07, 72 FR 73602.	
5–140–3710	Initial certification and recertification procedures.	4/18/07	12/28/07, 72 FR 73602.	
5–140–3720	Out of control periods	4/18/07	12/28/07, 72 FR 73602.	
5–140–3730	Notifications	4/18/07	12/28/07, 72 FR 73602.	
5–140–3740	Recordkeeping and reporting	4/18/07	12/28/07, 72 FR 73602.	
5–140–3750	Petitions	4/18/07	12/28/07, 72 FR 73602.	
Article 9 CAIR SO_2 Opt-in Units				
5–140–3800	Applicability	4/18/07	12/28/07, 72 FR 73602.	

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5–140–3810	General	4/18/07	12/28/07, 72 FR 73602.	
5–140–3820	CAIR-designated representative	4/18/07	12/28/07, 72 FR 73602.	
5–140–3830	Applying for CAIR opt-in permit	4/18/07	12/28/07, 72 FR 73602.	
5–140–3840	Opt-in process	4/18/07	12/28/07, 72 FR 73602.	
5–140–3850	CAIR opt-in permit contents	4/18/07	12/28/07, 72 FR 73602.	
5–140–3860	Withdrawal from CAIR SO_2 Trading Program.	4/18/07	12/28/07, 72 FR 73602.	
5–140–3870	Change in regulatory status	4/18/07	12/28/07, 72 FR 73602.	
5–140–3880	CAIR SO_2 allowance allocations to CAIR SO_2 opt-in units.	4/18/07	12/28/07, 72 FR 73602.	
9 VAC 5, Chapter 160 Regulation for General Conformity				
Part I General Definitions				
5–160–10	General	1/1/98	1/7/03, 68 FR 663.	
5–160–20	Terms Defined	1/1/97	10/21/97, 62 FR 54585.	
5–160–20	Terms Defined	1/1/97, 1/1/98	1/7/03, 68 FR 663	Terms revised—Emergency Terms deleted—Administrative Process Act, Confidential information, Consent agreement, Consent order, Emergency special order, Formal hearing, Order, Party, Public hearing, Special order, Variance, Virginia Register Act.
Part II General Provisions				
5–160–30	Applicability	1/1/97	10/21/97, 62 FR 54585.	
5–160–40	Authority of board and department	1/1/97	10/21/97, 62 FR 54585.	
5–160–80	Relationship of state regulations to Federal regulations.	1/1/97	10/21/97, 62 FR 54585.	
Part III Criteria and Procedures for Making Conformity Determinations				
5–160–110	General	1/1/97	10/21/97, 62 FR 54585	§ 52.2465(c)(118).
5–160–120	Conformity analysis	1/1/97	10/21/97, 62 FR 54585.	
5–160–130	Reporting requirements	1/1/97	10/21/97, 62 FR 54585.	
5–160–140	Public participation	1/1/97	10/21/97, 62 FR 54585.	
5–160–150	Frequency of conformity determinations.	1/1/97	10/21/97, 62 FR 54585.	
5–160–160	Criteria for determining conformity	1/1/97	10/21/97, 62 FR 54585.	
5–160–170	Procedures for conformity determinations.	1/1/97	10/21/97, 62 FR 54585.	
5–160–180	Mitigation of air quality impacts	1/1/97	10/21/97, 62 FR 54585.	
5–160–190	Savings provision	1/1/97	10/21/97, 62 FR 54585.	
5–160–200	Review and confirmation of this chapter by board.	1/1/97	10/21/97, 62 FR 54585.	
9 VAC 5, Chapter 170 Regulation for General Administration				
Part I Definitions				
5–170–10	Use of Terms	1/1/98	1/7/03, 68 FR 663	Split out from 9 VAC 5–10–10.
5–170–20	Terms Defined	1/1/98	1/7/03, 68 FR 663	Split out from 9 VAC 5–10–20 and 5–160–20. Terms Added-Public hearing, Regulation of the Board Terms Revised from 4/17/95 version-Consent agreement, Consent order, Emergency special order, Order, Owner, Person, Pollutant, Special Order, Source.
Part II General Provisions				
5–170–30	Applicability	1/1/98	1/7/03, 68 FR 663	Split out from 9 VAC 5–20–10.
5–170–60	Availability of Information	1/1/98	1/7/03, 68 FR 663	Replaces 9 VAC 5–20–150 and 5–160–100.

EPA-APPROVED VIRGINIA REGULATIONS AND STATUTES—Continued

State citation	Title/subject	State effective date	EPA approval date	Explanation [former SIP citation]
Part V Enforcement				
5–170–120A.–C.	Enforcement of Regulations, Permits and Orders.	1/1/98	1/7/03, 68 FR 663	Replaces 9 VAC 5–20–30A. D. and 5–160–60.
5–170–130A.	Right of Entry	1/1/98	1/7/03, 68 FR 663	Replaces 9 VAC 5–20–100.
Part VI Board Actions				
5–170–150	Local Ordinances	1/1/98	1/7/03, 68 FR 663	Replaces 9 VAC 5–20–60.
5–170–160	Conditions on Approvals	1/1/98	1/7/03, 68 FR 663	Replaces 9 VAC 5–20–110.
5–170–170	Considerations for Approval Actions ...	1/1/98	1/7/03, 68 FR 663	Replaces 9 VAC 5–20–140.
9 VAC 5, Chapter 200 National Low Emission Vehicle Program				
5–200–10	Definitions	4/14/99	12/28/99, 64 FR 72564.	
5–200–20	Participation in national LEV	4/14/99	12/28/99, 64 FR 72564.	
5–200–30	Transition from national LEV requirements to a Virginia Sec. 177 program.	4/14/99	12/28/99, 64 FR 72564.	
9 VAC 5, Chapter 230 Variance for International Paper Franklin Paper Mill				
5–230–10	Applicability and designation of affected facility.	9/7/05	8/13/07, 45 FR 45165.	
5–230–20	Definitions	9/7/05	8/13/07, 45 FR 45165.	
5–230–30	Authority to operate under this chapter and FESOP.	9/7/05	8/13/07, 45 FR 45165.	
5–230–40 (Except A.7., A.9., A.10., and B.2.).	Sitewide Emissions Caps	9/7/05	8/13/07, 45 FR 45165.	
5–230–50	New Source Review program and registration requirements.	9/7/05	8/13/07, 45 FR 45165.	
5–230–60 (Except A 1.).	Other regulatory requirements	9/7/05	8/13/07, 45 FR 45165.	
5–230–70	Federal Operating Permits	9/7/05	8/13/07, 45 FR 45165.	
5–230–80	FESOP issuance and amendments	9/7/05	8/13/07, 45 FR 45165.	
5–230–90	Transfer of ownership	9/7/05	8/13/07, 45 FR 45165.	
5–230–110	Termination of authority to operate under this chapter and FESOP.	9/7/05	8/13/07, 45 FR 45165.	
5–230–120	Review and confirmation of this chapter by Board.	9/7/05	8/13/07, 45 FR 45165.	
2 VAC 5, Chapter 480 Regulation Governing the Oxygenation of Gasoline				
5–480–10	Definitions	11/1/93	1/7/03, 68 FR 663	VR115–04–28, § 1.
5–480–20	Applicability	11/1/96	2/17/00, 65 FR 8051.	
5–480–30	Minimum oxygenate content	11/1/93	1/7/03, 68 FR 663	VR115–04–28, § 3.
5–480–40	Nature of oxygenates	11/1/93	1/7/03, 68 FR 663	VR115–04–28, § 4.
5–480–50	Record keeping and transfer requirements.	11/1/93	1/7/03, 68 FR 663	VR115–04–28, § 5.
5–480–60	Gasoline pump labeling	11/1/93	1/7/03, 68 FR 663	VR115–04–28, § 6.
5–480–70	Sampling, testing and oxygen content calculations.	11/1/93	1/7/03, 68 FR 663	VR115–04–28, § 7.
5–480–80	Compliance and enforcement	11/1/93	1/7/03, 68 FR 663	VR115–04–28, § 8.
Code of Virginia				
Section 10.1–1316.1A. Through D.	Severe ozone nonattainment areas; fees.	7/1/04	12/29/04, 69 FR 77909	Provision authorizes the Department of Environmental Quality (DEQ) to collect Federal penalty fees from major stationary sources if the nonattainment area does not attain the ozone standard by the statutory attainment date.

(d) EPA-Approved State Source-Specific Requirements

EPA-APPROVED SOURCE SPECIFIC REQUIREMENTS

Source name	Permit/order or registration number	State effective date	EPA approval date	40 CFR part 52 citation
Norfolk Naval Base-Exchange Service Station.	[NONE]	8/6/79	8/17/81, 46 FR 41499	52.2465(c)(41).
Reynolds Metals Co.-Rolling Mill	DSE–597–87	9/30/87	8/20/90, 55 FR 33904	52.2465(c)(92).
Aqualon (Hercules) Company	50363	9/26/90	11/1/91, 56 FR 56159	52.2465(c)(93).
Nabisco Brands, Inc	DTE–179–91	4/24/91	3/6/92, 57 FR 8080	52.2465(c)(95).
Reynolds Metals Co.-Bellwood	DSE–413A–86	10/31/86	6/13/96, 61 FR 29963	52.2465(c)(110).
Reynolds Metals Co.-Richmond Foil Plant.	DSE–412A–86	10/31/86	6/13/96, 61 FR 29963	52.2465(c)(110).
Philip Morris, Inc.—Blended Leaf Facility.	50080	2/27/86	10/14/97, 62 FR 53277	52.2465(c)(120).
Philip Morris, Inc.—Park 500 Facility.	50722	3/26/97	10/14/97, 62 FR 53277	52.2465(c)(120).
Philip Morris, Inc.—Richmond Manufacturing Center.	50076	7/13/96	10/14/97, 62 FR 53277	52.2465(c)(120).
Virginia Electric and Power Co.—Innsbrook Technical Center.	50396	5/30/96	10/14/97, 62 FR 53277	52.2465(c)(120).
Hercules, Inc.-Aqualon Division	V–0163–96	7/12/96	10/14/97, 62 FR 53277	52.2465(c)(120).
City of Hopewell-Regional Wastewater Treatment Facility.	50735	5/30/96	10/14/97, 62 FR 53277	52.2465(c)(120).
Allied Signal, Inc.-Hopewell Plant	50232	3/26/97	10/14/97, 62 FR 53277	52.2465(c)(121).
Allied Signal, Inc.-Chesterfield Plant.	V–0114–96	5/20/96	10/14/97, 62 FR 53277	52.2465(c)(121).
Bear Island Paper Co. L.P	V–0135–96	7/12/96	10/14/97, 62 FR 53277	52.2465(c)(121).
Stone Container Corp.—Hopewell Mill.	50370	5/30/96	10/14/97, 62 FR 53277	52.2465(c)(121).
E.I. Dupont de Nemours and Co.—Spruance Plant.	V–0117–96	5/30/96	10/14/97, 62 FR 53277	52.2465(c)(121).
ICI Americas Inc.—Films Division-Hopewell Site.	50418	5/30/96	10/14/97, 62 FR 53277	52.2465(c)(121).
Tuscarora, Inc	71814	6/5/96	1/22/99, 64 FR 3425	52.2465(c)(128).
Potomac Electric Power Company (PEPCO)–Potomac River Generating Station [Permit to Operate].	Registration No. 70228; County-Plant No. 510–0003.	9/18/00	12/14/00, 65 FR 78100	52.2420(d)(2).
Virginia Power (VP)—(Possum Point Generating Station [Permit to Operate].	Registration No. 70225; County-Plant No. 153–0002.	9/26/00	12/14/00, 65 FR 78100	52.2420(d)(2).
Cellofoam North America, Inc.—Falmouth Plant [Consent Agreement].	Registration No. 40696; FSO–193–98.	8/10/98	1/02/01, 66 FR 8	52.2420(d)(3).
CNG Transmission Corporation—Leesburg Compressor Station [Permit to Operate].	Registration No. 71978; County-Plant No. 107–0101.	5/22/00	1/02/01, 66 FR 8	52.2420(d)(3).
Columbia Gas Transmission Company—Loudoun County Compressor Station [Permit to Operate].	Registration No. 72265; County-Plant No. 107–0125.	5/23/00	1/02/01, 66 FR 8	52.2420(d)(3).
District of Columbia's Department of Corrections—Lorton Correctional Facility [Permit to Operate].	Registration No. 70028; County-Plant No. 0059–0024.	12/10/99	1/02/01, 66 FR 8	52.2420(d)(3).
Michigan Cogeneration Systems, Inc.—Fairfax County I–95 Landfill [Permit to Operate].	Registration No. 71961; County-Plant No. 0059–0575.	5/10/00	1/02/01, 66 FR 8	52.2420(d)(3).
Metropolitan Washington Airports Authority—Ronald Reagan Washington National Airport [Permit to Operate].	Registration No. 70005; County-Plant No. 0013–0015.	5/22/00	1/02/01, 66 FR 8	52.2420(d)(3).
Norman M. Cole, Jr., Pollution Control Plant [Consent Agreement].	Registration No. 70714	12/13/99	1/02/01, 66 FR 8	52.2420(d)(3).
Ogden Martin Systems of Alexandria/Arlington, Inc. [Consent Agreement].	Registration No. 71895; NVRO–041–98.	7/31/98	1/02/01, 66 FR 8	52.2420(d)(3).
Ogden Martin Systems of Fairfax, Inc. [Consent Agreement].	Registration No. 71920	4/3/98	1/02/01, 66 FR 8	52.2420(d)(3).
U.S. Department of Defense—Pentagon Reservation [Permit to Operate].	Registration No. 70030; County-Plant No. 0013–0188.	5/17/00	1/02/01, 66 FR 8	52.2420(d)(3).

EPA-APPROVED SOURCE SPECIFIC REQUIREMENTS—Continued

Source name	Permit/order or registration number	State effective date	EPA approval date	40 CFR part 52 citation
Potomac Electric Power Company (PEPCO)—Potomac River Generating Station [Consent Agreement].	Registration No. 70228; NVRO–106–98.	7/31/98	1/02/01, 66 FR 8	52.2420(d)(3), NO_X RACT requirements.
Potomac Electric Power Company (PEPCO)—Potomac River Generating Station.	Registration No. 70228; County Plant No. 510–0003.	5/8/00	1/02/01, 66 FR 8	52.2420(d)(3) VOC RACT requirements.
United States Marine Corps.—Quantico Base [Permit to Operate].	Registration No. 70267; County-Plant No. 153–0010.	5/24/00	1/02/01, 66 FR 8	52.2420(d)(3).
Transcontinental Gas Pipeline Corporation—Compressor Station No.185 [Consent Agreement].	Registration No. 71958	9/5/96	1/02/01, 66 FR 8	52.2420(d)(3).
U.S. Army Garrison at Fort Belvoir [Permit to Operate].	Registration No. 70550; County-Plant No. 059–0018.	5/16/00	1/02/01, 66 FR 8	52.2420(d)(3).
Virginia Power (VP)—(Possum Point Generating Station [Permit containing NO_X RACT requirements].	Registration No. 70225; County-Plant No. 153–0002.	7/21/00	1/02/01, 66 FR 8	52.2420(d)(3).
Virginia Electric and Power Company—Possum Point Generating Station [Consent Agreement containing VOC RACT requirements].	Registration No. 70225	6/12/95	1/02/01, 66 FR 8	52.2420(d)(3).
Washington Gas Light Company—Springfield Operations Center [Consent Agreement].	Registration No. 70151; NVRO–031–98.	4/3/98	1/02/01, 66 FR 8	52.2420(d)(3).
Georgia Pacific—Jarratt Softboard Plant.	Registration No. 50253	9/28/98	3/26/03, 68 FR 14542	40 CFR 52.2420(d)(4); *Note:* In Section E, Provision 1, the portion of the text which reads '' * * * and during periods of start-up, shutdown, and malfunction.'' is not part of the SIP.
Prince William County Landfill	Registration No. 72340	4/16/04	9/9/04, 69 FR 54581 ...	52.2420(d)(5).
Washington Gas Company, Ravensworth Station.	Registration No. 72277	4/16/04 8/11/04	10/6/04, 69 FR 59812	52.2420(d)(6).
Central Intelligence Agency (CIA), George Bush Center for Intelligence.	Registration No. 71757	4/16/04	12/13/04, 69 FR 72115	52.2420(d)(6).
National Reconnaissance Office, Boeing Service Center.	Registration No. 71988	4/16/04	12/13/04, 69 FR 72115	52.2420(d)(6).
Roanoke Electric Steel Corp	Registration No. 20131	12/22/04	4/27/05, 70 FR 21621	52.2420(d)(7).
Roanoke Cement Company	Registration No. 20232	12/22/04	4/27/05, 70 FR 21621	52.2420(d)(7).
Global Stone Chemstone Corporation.	Registration No. 80504	02/9/05	4/27/05, 70 FR 21621	52.2420(d)(7).
Kraft Foods Global, Inc.—Richmond Bakery.	Registration No. 50703	9/19/07	4/15/08, 73 FR 20175	52.2420(d)(8).
Transcontinental Pipeline Station 165.	Registration No. 30864	1/24/07	10/30/08, 73 FR 64551	52.2420(d)(9).
Transcontinental Pipeline Station 170.	Registration No. 30863	1/24/07	10/30/08, 73 FR 64551	52.2420(d)(9).
Transcontinental Pipeline Station 175.	Registration No. 40789	1/30/07	10/30/08, 73 FR 64551	52.2420(d)(9).
Transcontinental Pipeline Station 180.	Registration No. 40782	2/13/07	10/30/08, 73 FR 64551	52.2420(d)(9).
Roanoke Cement Corporation	Registration No. 20232	6/18/07	10/30/08, 73 FR 64551	52.2420(d)(9).
Reynolds Consumer Products Company.	Registration No. 50534	10/1/08	3/25/09, 74 FR 12572	52.2420(d)(12). The SIP effective date is 5/26/09.

(e) *EPA-approved nonregulatory and quasi-regulatory material.*

Name of non-regulatory SIP revision	Applicable geographic area	State submittal date	EPA approval date	Additional explanation
Commitment Letter—Clean fuel fleet or alternative substitute program.	Northern Virginia Ozone nonattainment Area.	1/25/93	9/23/93, 58 FR 50846	52.2423(j).
9 VAC 5–60–100 (adopts 40 CFR 63.460 through 63.469 by reference).	Statewide	10/9/98	11/3/99, 64 FR 59648	52.2423(q).
Documents Incorporated by Reference.	Statewide	4/12/89	8/23/95, 60 FR 43714	52.2423(m).
Documents Incorporated by Reference.	Statewide	2/12/93	8/23/95, 60 FR 43714	52.2423(n).
Documents Incorporated by Reference (9 VAC 5–20–21, Section E).	Statewide	6/22/99	1/7/03, 68 FR 663	52.2423(r).
Documents Incorporated by Reference (9 VAC 5–20–21, paragraph E.12).	Statewide	2/23/04	6/8/04, 69 FR 31893	52.2423(s).
Documents Incorporated by Reference.	Northern Virginia VOC Emissions Control Area designated in 9 VAC 5–20–206.	3/24/04	5/12/05, 70 FR 24970	9 VAC 5–20–21, Sections E.1.a.(7)., E.4.a.(12) through a.(17), E.10., E.11., E.13.a.(1), and E.13.a.(2).
Documents Incorporated by Reference (9 VAC 5–20–21, Sections D., E. (introductory sentence), E.2 (all paragraphs), E.3.b, E.4.a.(1) and (2), E.4.b., E.5. (all paragraphs), and E.7. (all paragraphs)).	Statewide	8/25/05	3/3/06, 71 FR 10838	State effective date is 2/1/00.
Documents Incorporated by Reference (9 VAC 5–20–21, Section B.	Statewide	10/25/05	3/3/06, 71 FR 10838	State effective date is 3/9/05; approval is for those provisions of the CFR which implement control programs for air pollutants related to the national ambient air quality standards (NAAQS) and regional haze.
Documents Incorporated by Reference.	Northern Virginia VOC Emissions Control Area designated in 9 VAC 5–20–206.	10/25/05	1/30/07, 72 FR 4207	State effective date is 3/9/05. 9 VAC 5–20–21, Sections E.1.a.(16)., E.4.a.(18) through a.(20), E.6.a, E.11.a.(3), E.12.a.(5) through a.(8), E.14.a. and E.14.b.
Documents Incorporated by Reference (9 VAC 5–20–21, Paragraphs E.4.a. (21) and (22)).	Fredericksburg VOC Emissions Control Area Designated in 9 VAC 5–20–206.	05/14/07	12/5/07, 72 FR 68511	State effective date is 10/04/06.
Motor vehicle emissions budgets	Hampton Roads Ozone Maintenance Area.	8/29/96	6/26/97, 62 FR 34408	52.2424(a).
Motor vehicle emissions budgets	Richmond Ozone Maintenance Area.	7/30/96	11/17/97, 62 FR 61237	52.2424(b).
1990 Base Year Emissions Inventory-Carbon Monoxide (CO).	Metropolitan Washington Area ..	11/1/93 4/3/95 10/12/95	1/30/96, 61 FR 2931	52.2425(a).
1990 Base Year Emissions Inventory-Carbon Monoxide (CO), oxides of nitrogen (NO_X), & volatile organic compounds (VOC).	Richmond-Petersburg, Norfolk-Virginia Beach, and Smyth County Ozone Areas.	11/11/92 11/18/92 11/1/93 12/15/94	9/16/96, 61 FR 48657	52.2425(b).
1990 Base Year Emissions Inventory-Carbon Monoxide (CO), oxides of nitrogen (NO_X), & volatile organic compounds (VOC).	Northern Virginia (Metropolitan Washington) Ozone Nonattainment Area.	11/30/92 11/1/93 4/3/95	9/16/96, 61 FR 54656	52.2425(c).
1990 Base Year Emissions Inventory-oxides of nitrogen (NO_X), & volatile organic compounds (VOC).	Northern Virginia (Metropolitan Washington) Ozone Nonattainment Area.	12/17/97	7/8/98, 63 FR 36854.	
Photochemical Assessment Monitoring Stations (PAMS) Program.	Northern Virginia (Metropolitan Washington) Ozone Nonattainment Area.	11/15/94	9/11/95, 60 FR 47081	52.2426.
Attainment determination of the ozone NAAQS.	Richmond Ozone Nonattainment Area.	7/26/96	10/6/97, 62 FR 52029	52.2428(a).

Name of non-regulatory SIP revision	Applicable geographic area	State submittal date	EPA approval date	Additional explanation
15% rate of progress plan	Northern Virginia (Metropolitan Washington) Ozone Non-attainment Area.	4/14/98	10/6/00, 65 FR 59727	52.2428(b).
Small business stationary source technical and environmental assistance program.	Statewide	11/10/92	2/14/94, 59 FR 5327	52.2460.
Establishment of Air Quality Monitoring Network.	Statewide	3/24/80	12/5/80, 45 FR 86530	52.2465(c)(38).
Lead (Pb) SIP	Statewide	12/31/80	3/21/82, 45 FR 8566	52.2465(c)(61).
Carbon Monoxide Maintenance Plan.	Arlington County & Alexandria City.	10/4/95	1/30/96, 61 FR 2931	52.2465(c)(107).
		3/22/04	04/04/05, 70 FR 16958	Revised Carbon Monoxide Maintenance Plan Base Year Emissions Inventory using MOBILE6.
Ozone Maintenance Plan, emissions inventory & contingency measures.	Hampton Roads Area	8/27/96	6/26/97, 62 FR 34408	52.2465(c)(117).
Ozone Maintenance Plan, emissions inventory & contingency measures.	Richmond Area	7/26/96	11/17/97, 62 FR 61237	52.2465(c)(119).
Non-Regulatory Voluntary Emission Reduction Program.	Washington, DC, severe 1-hour ozone nonattainment area.	2/25/04	5/12/05, 70 FR 24987	The nonregulatory measures found in section 7.6 and Appendix J of the plan.
1996–1999 Rate-of-Progress Plan SIP and the Transportation Control Measures (TCMs) in Appendix H.	Washington 1-hour ozone non-attainment area.	12/29/03 5/25/99	5/16/05, 70 FR 25688	Only the TCMs in Appendix H of the 5/25/1999 revision, 1999 motor vehicle emissions budgets of 128.5 tons per day (tpy) of VOC and 196.4 tpy of NO_X.
1990 Base Year Inventory Revisions.	Washington 1-hour ozone non-attainment area.	8/19/03 2/25/04	5/16/05, 70 FR 25688.	
1999–2005 Rate-of-Progress Plan SIP Revision and the Transportation Control Measures (TCMs) in Appendix J.	Washington 1-hour ozone non-attainment area.	8/19/03 2/25/04	5/16/05, 70 FR 25688	Only the TCMs in Appendix J of the 2/25/2004 revision, 2002 motor vehicle emissions budgets (MVEBs) of 125.2 tons per day (tpy) for VOC and 290.3 tpy of NO_X, and, 2005 MVEBs of 97.4 tpy for VOC and 234.7 tpy of NO_X.
VMT Offset SIP Revision	Washington 1-hour ozone non-attainment area.	8/19/03 2/25/04	5/16/05, 70 FR 25688.	
Contingency Measure Plan	Washington 1-hour ozone non-attainment area.	8/19/03 2/25/04	5/16/05, 70 FR 25688.	
1-Hour Ozone Modeled Demonstration of Attainment and Attainment Plan.	Washington 1-hour ozone non-attainment area.	8/19/03 2/25/04	5/16/05, 70 FR 25688	2005 motor vehicle emissions budgets of 97.4 tons per day (tpy) for VOC and 234.7 tpy of NO_X.
Attainment Demonstration and Early Action Plan for the Roanoke MSA Ozone Early Action Compact Area.	Botetourt County, Roanoke City, Roanoke County, and Salem City.	12/21/04 2/15/05	8/17/05, 70 FR 43277.	
Attainment Demonstration and Early Action Plan for the Northern Shenandoah Valley Ozone Early Action Compact Area.	City of Winchester and Frederick County.	12/20/04 02/15/05	8/17/05, 70 FR 43280.	
8-Hour Ozone Maintenance Plan for the Fredericksburg VA Area.	City of Fredericksburg, Spotsylvania County, and Stafford County.	5/4/05	12/23/05, 70 FR 76165.	
8-Hour Ozone Maintenance Plan for the Madison & Page Cos. (Shenandoah NP), VA Area.	Madison County (part) and Page County (part).	9/23/05	1/3/05, 71 FR 24.	
8-Hour Ozone Maintenance Plan and 2002 Base Year Emissions Inventory.	Norfolk-Virginia Beach-Newport News (Hampton Roads), VA Area.	10/12/06 10/16/06 10/18/06 11/20/06 2/13/07	6/1/07, 72 FR 30490	The SIP effective date is 6/1/07.
8-Hour Ozone Maintenance Plan and 2002 Base Year Emissions Inventory.	Richmond-Petersburg VA Area	9/18/06 9/20/06 9/25/06 11/17/06 2/13/07	6/1/07, 72 FR 30485	The SIP effective date is 6/18/07.

Name of non-regulatory SIP revision	Applicable geographic area	State submittal date	EPA approval date	Additional explanation
Ozone Maintenance Plan	White Top Mountain, Smyth County, VA 1-hour Ozone Nonattainment Area.	8/6/07	4/29/08, 73 FR 23103.	
RACT under the 8-Hour NAAQS	Stafford County	4/21/08	12/22/08, 73 FR 78192.	

[FR Doc. E9–16366 Filed 7–10–09; 8:45 am]
BILLING CODE 6560–60–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

44 CFR Part 65

[Docket ID FEMA–2008–0020; Internal Agency Docket No. FEMA–B–1059]

Changes in Flood Elevation Determinations

AGENCY: Federal Emergency Management Agency, DHS.
ACTION: Interim rule.

SUMMARY: This interim rule lists communities where modification of the Base (1% annual-chance) Flood Elevations (BFEs) is appropriate because of new scientific or technical data. New flood insurance premium rates will be calculated from the modified BFEs for new buildings and their contents.

DATES: These modified BFEs are currently in effect on the dates listed in the table below and revise the Flood Insurance Rate Maps (FIRMs) in effect prior to this determination for the listed communities.

From the date of the second publication of these changes in a newspaper of local circulation, any person has ninety (90) days in which to request through the community that the Mitigation Assistant Administrator of FEMA reconsider the changes. The modified BFEs may be changed during the 90-day period.

ADDRESSES: The modified BFEs for each community are available for inspection at the office of the Chief Executive Officer of each community. The respective addresses are listed in the table below.

FOR FURTHER INFORMATION CONTACT: William R. Blanton Jr., Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street SW., Washington, DC 20472, (202) 646–3151.

SUPPLEMENTARY INFORMATION: The modified BFEs are not listed for each community in this interim rule. However, the address of the Chief Executive Officer of the community where the modified BFE determinations are available for inspection is provided.

Any request for reconsideration must be based on knowledge of changed conditions or new scientific or technical data.

The modifications are made pursuant to section 201 of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4105, and are in accordance with the National Flood Insurance Act of 1968, 42 U.S.C. 4001 *et seq.*, and with 44 CFR part 65.

For rating purposes, the currently effective community number is shown and must be used for all new policies and renewals.

The modified BFEs are the basis for the floodplain management measures that the community is required to either adopt or to show evidence of being already in effect in order to qualify or to remain qualified for participation in the National Flood Insurance Program (NFIP).

These modified BFEs, together with the floodplain management criteria required by 44 CFR 60.3, are the minimum that are required. They should not be construed to mean that the community must change any existing ordinances that are more stringent in their floodplain management requirements. The community may at any time enact stricter requirements of its own, or pursuant to policies established by the other Federal, State, or regional entities. The changes in BFEs are in accordance with 44 CFR 65.4.

National Environmental Policy Act. This interim rule is categorically excluded from the requirements of 44 CFR part 10, Environmental Consideration. An environmental impact assessment has not been prepared.

Regulatory Flexibility Act. As flood elevation determinations are not within the scope of the Regulatory Flexibility Act, 5 U.S.C. 601–612, a regulatory flexibility analysis is not required.

Regulatory Classification. This interim rule is not a significant regulatory action under the criteria of section 3(f) of Executive Order 12866 of September 30, 1993, Regulatory Planning and Review, 58 FR 51735.

Executive Order 13132, Federalism. This interim rule involves no policies that have federalism implications under Executive Order 13132, Federalism.

Executive Order 12988, Civil Justice Reform. This interim rule meets the applicable standards of Executive Order 12988.

List of Subjects in 44 CFR Part 65

Flood insurance, Floodplains, Reporting and recordkeeping requirements.

■ Accordingly, 44 CFR part 65 is amended to read as follows:

PART 65—[AMENDED]

■ 1. The authority citation for part 65 continues to read as follows:

Authority: 42 U.S.C. 4001 *et seq.*; Reorganization Plan No. 3 of 1978, 3 CFR, 1978 Comp., p. 329; E.O. 12127, 44 FR 19367, 3 CFR, 1979 Comp., p. 376.

§ 65.4 [Amended]

■ 2. The tables published under the authority of § 65.4 are amended as follows:

State and county	Location and case No.	Date and name of newspaper where notice was published	Chief executive officer of community	Effective date of modification	Community No.
Alabama:					
Mobile	Unincorporated areas of Mobile County (08–04–6003P).	May 11, 2009; May 18, 2009; *Press-Register.*	The Honorable Stephen Nodine, President, Mobile County Commission, 205 Government Street, Mobile, AL 36644.	September 15, 2009	015008
Montgomery	City of Montgomery (08–04–6322P).	May 11, 2009; May 18, 2009; *Montgomery Advertiser.*	The Honorable Todd Strange, Mayor, City of Montgomery, 103 North Perry Street, Montgomery, AL 36104.	September 15, 2009	010174

State and county	Location and case No.	Date and name of newspaper where notice was published	Chief executive officer of community	Effective date of modification	Community No.
Tuscaloosa	City of Northport (08–04–6551P).	May 11, 2009; May 18, 2009; *Tuscaloosa News*.	The Honorable Bobby Herndon, Mayor, City of Northport, 3500 McFarland Boulevard, Northport, AL 35476.	September 15, 2009	010202
Tuscaloosa	Unincorporated areas of Tuscaloosa County (08–04–6551P).	May 11, 2009; May 18, 2009; *Tuscaloosa News*.	The Honorable W. Hardy McCollum, Probate Judge, Tuscaloosa County, 714 Greensboro Avenue, Tuscaloosa, AL 35401.	September 15, 2009	010201
Arizona:					
Maricopa	City of El Mirage (08–09–1164P).	May 7, 2009; May 14, 2009; *Arizona Business Gazette*.	The Honorable Fred Waterman, Mayor, City of El Mirage, Post Office Box 26, El Mirage, AZ 85335.	April 30, 2009	040041
Maricopa	Unincorporated areas of Maricopa County (08–09–1164P).	May 7, 2009; May 14, 2009; *Arizona Business Gazette*.	The Honorable Andrew W. Kunasek, Chairman, Maricopa County Board of Supervisors, 301 West Jefferson Street, 10th Floor, Phoenix, AZ 85003.	April 30, 2009	040037
Maricopa	Unincorporated areas of Maricopa County (08–09–1294P).	May 7, 2009; May 14, 2009; *Arizona Business Gazette*.	The Honorable Andrew W. Kunasek, Chairman, Maricopa County Board of Supervisors, 301 West Jefferson Street, 10th Floor, Phoenix, AZ 85003.	April 23, 2009	040037
Maricopa	City of Phoenix (08–09–1294P).	May 7, 2009; May 14, 2009; *Arizona Business Gazette*.	The Honorable Phil Gordon, Mayor, City of Phoenix, 200 West Washington Street, 11th Floor, Phoenix, AZ 85003.	April 23, 2009	040051
Maricopa	City of Phoenix (08–09–1384P).	May 7, 2009; May 14, 2009; *Arizona Business Gazette*.	The Honorable Phil Gordon, Mayor, City of Phoenix, 200 West Washington Street, 11th Floor, Phoenix, AZ 85003.	September 11, 2009	040051
California:					
Sacramento	City of Elk Grove (08–09–1760P).	May 12, 2009; May 19, 2009; *The Sacramento Bee*.	The Honorable Patrick Hume, Mayor, City of Elk Grove, 8401 Laguna Palms Way, Elk Grove, CA 95758.	June 2, 2009	060767
Sacramento	Unincorporated areas of Sacramento County (08–09–1760P).	May 12, 2009; May 19, 2009; *The Sacramento Bee*.	The Honorable Susan Peters, Chair, Sacramento County Board of Supervisors, 700 H Street, Suite 2450, Sacramento, CA 95814.	June 2, 2009	060262
San Diego	City of Carlsbad (09–09–0276P).	May 1, 2009; May 8, 2009; *North County Times*.	The Honorable Claude A. Lewis, Mayor, City of Carlsbad, 1200 Carlsbad Village Drive, Carlsbad, CA 92008.	September 8, 2009	060285
Santa Barbara ..	City of Carpinteria (08–09–1482P).	April 27, 2009; May 4, 2009; *Santa Barbara News Press*.	The Honorable Gregg Carty, Mayor, City of Carpinteria, 5775 Carpinteria Avenue, Carpinteria, CA 93013.	May 15, 2009	060332
Santa Barbara ..	Unincorporated areas of Santa Barbara County (08–09–1482P).	April 27, 2009; May 4, 2009; *Santa Barbara News Press*.	The Honorable Salud Carbajal, Chairman, Santa Barbara County Board of Supervisors, 105 East Anapamu Street, Santa Barbara, CA 93101.	May 15, 2009	060331
Ventura	Unincorporated areas of Ventura County (08–09–1921P).	May 8, 2009; May 15, 2009; *Ventura Star*.	The Honorable Steve Bennett, Chairman, Ventura County Board of Supervisors, 800 South Victoria Avenue, Ventura, CA 93009.	September 14, 2009	060413
Connecticut:					
Tolland	Town of Coventry (09–01–0698P).	May 11, 2009; May 18, 2009; *Journal Inquirer*.	The Honorable Liz Woolf, Chairperson, Coventry Town Council, Town Hall, 1712 Main Street, Coventry, CT 06238.	September 15, 2009	090110
Colorado:					
Grand	Town of Granby (08–08–0416P).	April 30, 2009; May 7, 2009; *Middle Park Times*.	The Honorable Jynnifer Pierro, Mayor, Town of Granby, P.O. Box 440, Granby, CO 80446.	September 8, 2009	080248
Grand	Unincorporated areas of Grand County (08–08–0416P).	April 30, 2009; May 7, 2009; *Middle Park Times*.	The Honorable Nancy Stuart, Chairman, Grand County Board of Commissioners, P.O. Box 264, Hot Sulphur Springs, CO 80451.	September 8, 2009	080280
Florida:					
Charlotte	Unincorporated areas of Charlotte County (09–04–3000P.	May 11, 2009; May 18, 2009; *Charlotte Sun Herald*.	The Honorable Adam Cummings, Chairman, Board of Commissioners, Charlotte County, 18500 Murdock Circle, Port Charlotte, FL 33948.	April 30, 2009	120061
Marion	City of Ocala (08–04–4557P).	May 13, 2009; May 20, 2009; *Star-Banner*.	The Honorable Randy Ewers, Mayor, City of Ocala, P.O. Box 1270, Ocala, FL 34478–1270.	September 15, 2009	120330
Illinois:					
Will	Unincorporated areas of Will County (09–05–1623P).	May 11, 2009; May 18, 2009; *The Herald News*.	The Honorable Lawrence M. Walsh, Will County Executive, 302 North Chicago Street, Joliet, IL 60432.	September 15, 2009	170695
Indiana:					
Marion	City of Indianapolis (09–05–2436P).	May 8, 2009; May 15, 2009; *Indianapolis Recorder*.	The Honorable Gregory A. Ballard, Mayor, City of Indianapolis, 2501 City-County Building, 200 East Washington Street, Indianapolis, IN 46204.	April 30, 2009	180159
Missouri:					
St. Charles	City of St. Peters (09–07–0566P).	April 29, 2009; May 6, 2009; *St. Louis Post Dispatch*.	The Honorable Len Pagano, Mayor, City of St. Peters, One St. Peters Centre Boulevard, St. Peters, MO 63376.	April 21, 2009	290319
New Mexico:					

State and county	Location and case No.	Date and name of newspaper where notice was published	Chief executive officer of community	Effective date of modification	Community No.
Chaves	City of Roswell (09–06–0188P).	May 1, 2009; May 8, 2009; *Roswell Daily Record*.	The Honorable Sam D. LaGrone, Mayor, City of Roswell, 425 North Richardson Avenue, Roswell, NM 88201.	April 21, 2009	350006
New York:					
Rockland	Town of Ramapo (09–02–0256P).	May 11, 2009; May 18, 2009; *The Journal News*.	The Honorable Christopher St. Lawrence, Supervisor, Town of Ramapo, 237 Route 59, Suffern, NY 10901.	October 27, 2009	365340
Nevada:					
Clark	Unincorporated areas of Clark County (09–09–0526P).	May 12, 2009; May 19, 2009; *Las Vegas Review-Journal*.	The Honorable Rory Reid, Chair, Clark County Board of Commissioners, 500 South Grand Central Parkway, Las Vegas, NV 89106.	September 16, 2009	320003
Clark	City of Henderson (09–09–0526P).	May 12, 2009; May 19, 2009; *Las Vegas Review-Journal*.	The Honorable James B. Gibson, Mayor, City of Henderson, 240 South Water Street, Henderson, NV 89015.	September 16, 2009	320005
Clark	City of North Las Vegas (09–09–0019P).	May 8, 2009; May 15, 2009; *Las Vegas Review-Journal*.	The Honorable Michael L. Montandon, Mayor, City of North Las Vegas, 2200 Civic Center Drive, North Las Vegas, NV 89030.	September 14, 2009	320007
North Carolina: Pender.	Pender County (Unincorporated Areas) (08–04–6525P).	May 6, 2009; May 13, 2009; *The Pender Post*.	Mr. Rick Benton, Manager, Pender County, 805 South Walker Street, P.O. Box 5, Burgaw, North Carolina 28425.	September 10, 2009	370344
Oklahoma: Rogers	City of Catoosa (09–06–0354P).	May 6, 2009; May 13, 2009; *Catoosa Times*.	The Honorable Rita Lamkin, Mayor, City of Catoosa, P.O. Box 190, Catoosa, OK 74015.	April 29, 2009	400185
South Carolina: Charleston.	City of North Charleston (08–04–2279P).	April 30, 2009; May 7, 2009; *Post and Courier*.	The Honorable R. Keith Summery, Mayor, City of North Charleston, Post Office Box 190016, North Charleston, SC 29419.	September 3, 2009	450042
South Dakota: Lawrence.	City of Spearfish (09–08–0035P).	May 1, 2009; May 8, 2009; *Black Hills Pioneer*.	The Honorable Jerry Krambeck, Mayor, City of Spearfish, 233 Vermont Street,Spearfish, SD 57783.	April 23, 2009	460046
Texas:					
Brazos	City of College Station (08–06–2806P).	May 11, 2009; May 18, 2009; *Bryan College Station Eagle*.	The Honorable Ben White, Mayor, City of College Station, P.O. Box 9960, College Station, TX 77842.	June 2, 2009	480083
Collin	Town of Prosper (09–06–0211P).	May 11, 2009; May 18, 2009; *Dallas Morning News*.	The Honorable Charles Niswanger, Mayor, Town of Prosper, P.O. Box 307, Prosper, TX 75078.	September 15, 2009	480141
Dallas	City of Cedar Hill (08–06–2296P).	May 8, 2009; May 15, 2009; *Dallas Morning News*.	The Honorable Rob Franke, Mayor, City of Cedar Hill, 285 Uptown Boulevard, Cedar Hill, TX 75104.	September 14, 2009	480168
Dallas	City of Duncanville (08–06–2296P).	May 8, 2009; May 15, 2009; *Dallas Morning News*.	The Honorable David Green, Mayor, City of Duncanville, P.O. Box 380280, Duncanville, TX 75138.	September 14, 2009	480173
Denton	City of Frisco (08–06–3220P).	May 8, 2009; May 15, 2009; *Frisco Enterprise*.	The Honorable Maher Maso, Mayor, City of Frisco, 6101 Frisco Square Boulevard, Frisco, TX 75034.	May 29, 2009	480134
El Paso	City of El Paso (09–06–0832P).	May 13, 2009; May 20, 2009; *El Paso Times*.	The Honorable John Cook, Mayor, City of El Paso, City Hall, 10th Floor, Two Civic Center Plaza, El Paso, TX 79901.	September 17, 2009	480214
Galveston	City of League City (08–06–3081P).	May 8, 2009; May 15, 2009; *Galveston County Daily News*.	The Honorable Toni Randall, Mayor, City of League City, 300 West Walker Street, League City, TX 77573.	April 29, 2009	485488
Utah:					
Washington	City of LaVerkin (09–08–0296P).	April 23, 2009; April 30, 2009; *St. George Spectrum*.	The Honorable Karl Wilson, Mayor, City of LaVerkin, 435 North Main Street, LaVerkin, UT 84745.	August 28, 2009	490174
Washington	City of Toquerville (09–08–0296P).	April 23, 2009; April 30, 2009; *St. George Spectrum*.	The Honorable Kenneth Powell, Mayor, Town of Toquerville, P.O. Box 27, Toquerville, UT 84774.	August 28, 2009	490180
Wisconsin:					
Rock	Unincorporated areas of Rock County (08–05–4045P).	April 30, 2009; May 7, 2009; *Beloit Daily News*.	The Honorable J. Russell Podzilni, Chairman, Rock County, Board of Supervisors, 51 South Main Street, Janesvile, WI 53545.	September 11, 2009	550363
Walworth	Unincorporated areas of Walworth County (08–05–4045P).	May 7, 2009; May 14, 2009; *Elkhorn Independent*.	The Honorable Nancy Russell, Chairperson, Walworth County, Board of Supervisors, P.O. Box 1001, Elkhorn, WI 53121.	September 11, 2009	550462

(Catalog of Federal Domestic Assistance No. 97.022, ''Flood Insurance.'')

Dated: June 29, 2009.

Deborah S. Ingram,

Acting Deputy Assistant Administrator for Mitigation, Mitigation Directorate, Department of Homeland Security, Federal Emergency Management Agency.

[FR Doc. E9–16524 Filed 7–10–09; 8:45 am]

BILLING CODE 9110–12–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

44 CFR Part 67

Final Flood Elevation Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Final rule.

SUMMARY: Base (1% annual chance) Flood Elevations (BFEs) and modified BFEs are made final for the communities listed below. The BFEs and modified BFEs are the basis for the floodplain management measures that each community is required either to adopt or to show evidence of being already in effect in order to qualify or remain qualified for participation in the National Flood Insurance Program (NFIP).

DATES: The date of issuance of the Flood Insurance Rate Map (FIRM) showing BFEs and modified BFEs for each community. This date may be obtained by contacting the office where the maps are available for inspection as indicated on the table below.

ADDRESSES: The final BFEs for each community are available for inspection at the office of the Chief Executive Officer of each community. The respective addresses are listed in the table below.

FOR FURTHER INFORMATION CONTACT: William R. Blanton, Jr., Engineering Management Section, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street SW., Washington, DC 20472, (202) 646–3151.

SUPPLEMENTARY INFORMATION: The Federal Emergency Management Agency (FEMA) makes the final determinations listed below for the modified BFEs for each community listed. These modified elevations have been published in newspapers of local circulation and ninety (90) days have elapsed since that publication. The Mitigation Division Director of FEMA has resolved any appeals resulting from this notification.

This final rule is issued in accordance with section 110 of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4104, and 44 CFR part 67. FEMA has developed criteria for floodplain management in floodprone areas in accordance with 44 CFR part 60.

Interested lessees and owners of real property are encouraged to review the proof Flood Insurance Study and FIRM available at the address cited below for each community.

The BFEs and modified BFEs are made final in the communities listed below. Elevations at selected locations in each community are shown.

National Environmental Policy Act. This final rule is categorically excluded from the requirements of 44 CFR part 10, Environmental Consideration. An environmental impact assessment has not been prepared.

Regulatory Flexibility Act. As flood elevation determinations are not within the scope of the Regulatory Flexibility Act, 5 U.S.C. 601–612, a regulatory flexibility analysis is not required.

Regulatory Classification. This final rule is not a significant regulatory action under the criteria of section 3(f) of Executive Order 12866 of September 30, 1993, Regulatory Planning and Review, 58 FR 51735.

Executive Order 13132, Federalism. This final rule involves no policies that have federalism implications under Executive Order 13132.

Executive Order 12988, Civil Justice Reform. This final rule meets the applicable standards of Executive Order 12988.

List of Subjects in 44 CFR Part 67

Administrative practice and procedure, Flood insurance, Reporting and recordkeeping requirements.

■ Accordingly, 44 CFR part 67 is amended as follows:

PART 67—[AMENDED]

■ 1. The authority citation for part 67 continues to read as follows:

Authority: 42 U.S.C. 4001 *et seq.*; Reorganization Plan No. 3 of 1978, 3 CFR, 1978 Comp., p. 329; E.O. 12127, 44 FR 19367, 3 CFR, 1979 Comp., p. 376.

§ 67.11 [Amended]

■ 2. The tables published under the authority of § 67.11 are amended as follows:

State	City/town/county	Source of flooding	Location	# Depth in feet above ground. * Elevation in feet (NGVD) + Elevation in feet (NAVD) Modified
Town of North Canaan, Connecticut Docket No.: FEMA–B–7472				
Connecticut	Town of North Canaan	Blackberry River	Approximately 700 feet downstream of Route 44.	+656
			Approximately 1,050 feet upstream of Route 7.	+672

Depth in feet above ground.
* National Geodetic Vertical Datum.
+ North American Vertical Datum.

ADDRESSES

Maps are available for inspection at Town Hall, 100 Pease Street, Canaan, Connecticut 06018.

State	City/town/county	Source of flooding	Location	* Elevation in feet (NGVD) +Elevation in feet (NAVD) # Depth in feet above ground Modified
Town of Van Buren, Maine Docket No.: FEMA–B–7708				
Maine	Town of Van Buren	Violette Brook	At confluence of Violette Stream	+468
			Just upstream of Castonguay Road	+530
			Approximately 2,500 feet upstream of private road at the Corporate Limits.	+608
Maine	Town of Van Buren	Violette Stream	At Bangor and Aroostook Railroad	+451
			At confluence of Violette Brook	+468
			Approximately 1,000 feet upstream of Champlain Street.	+483

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.

ADDRESSES

Town of Van Buren
Maps are available for inspection at 51 Main Street, Suite 101, Van Buren, ME 04785.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground Modified	Communities affected
Village of Cambridge, New York Docket No.: FEMA–B–7711			
Cambridge Creek	Confluence with Owl Kill	+477	Village of Cambridge.
	Approximately 3,000 feet upstream of State Route 372	+508	
Owl Kill	Approximately 850 feet upstream of County Route 71	+466	Village of Cambridge.
	Approximately 1,000 feet upstream of N. Park Street	+493	
White Creek	Corporate limits of Village of Cambridge	+493	Village of Cambridge.
	Approximately 150 feet downstream of corporate limits of Village of Cambridge.	+523	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.

ADDRESSES

Village of Cambridge
Maps are available for inspection at 23 West Main Street, Cambridge, NY 12819.

Grand County, Colorado and Incorporated Areas Docket No.: FEMA–B–7705			
Fraser River	Approximately 1,700 ft upstream of the intersection with State Highway 8.	+8550	Town of Fraser, Grand County, (Unincorporated Areas).
	Approximately 2,445 ft downstream of the confluence with Leland Creek.	+8628	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.

ADDRESSES

Town of Fraser
Maps are available for inspection at 153 Fraser Avenue, Fraser, CO 80442.

Grand County (Unincorporated Areas)
Maps are available for inspection at 308 Byers Avenue, Hot Sulphur Springs, CO 80451.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground Modified	Communities affected
Edwards County, Kansas and Incorporated Areas Docket No.: FEMA–B–7705			
Arkansas River	At U.S. Highway 50	+2160	Edwards County (Unincorporated Areas).
	Approximately 2 miles upstream of Old U.S. Highway 183	+2187	
Big Coon Creek	At U.S. Highway 50	+2164	Edwards County (Unincorporated Areas), City of Kinsley.
	At Colony Avenue	+2172	
	Approximately 1 mile upstream of Winchester Avenue	+2179	
Little Coon Creek	At Winchester Avenue	+2169	Edwards County (Unincorporated Areas).
	Approximately 2 miles upstream of County Road 13	+2183	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.

ADDRESSES

Edwards County (Unincorporated Areas)

Maps are available for inspection at the County Clerk's Office, 312 Massachusetts Avenue, Kinsley, KS 67547.

City of Kinsley

Maps are available for inspection at City Hall, 721 Marsh, Kinsley, KS 67547.

Dodge County, Nebraska and Incorporated Areas Docket No.: FEMA–B–7705			
Platte River (levee failure)	At Downing Street, south of Union Pacific Railroad	+1188	City of Fremont, City of Inglewood, City of North Bend, Unincorporated Areas of Dodge County.
	At U.S. Highway 77	+1197	
	Approximately 1 mile downstream of State Highway 79	+1268 1279	
	South of U.S. Highway 30 at County Road 5	+1287	
Platte River (levee)	Approximately ½ mile downstream of Burlington Northern Railroad.	+1195	City of Fremont, City of Inglewood, City of North Bend, Dodge County (Unincorporated Areas).
	At U.S. Highway 77	+1201	
	At County Road 19, south of Union Pacific Railroad	+1216	
	Approximately 1 mile downstream of State Highway 79	+1272	
	Approximately 1 mile upstream of State Highway 79	+1285	
	South of Union Pacific Railroad, just upstream of County Road 3.	+1300	
Platte River Overflow	Just north of 23rd Street, west of Burlington Northern Railroad.	#2	City of Fremont, City of Inglewood, City of North Bend, Dodge County (Unincorporated Areas).
	At the intersection of County Road 5 and County Road S	#2	
	Between U.S. Highway 275 and Old Highway 8	#2	
	East of Burlington Northern Railroad and north of U.S. Highway 30/Highway 275.	#2	
	Between U.S. Highway 30 and Burlington Northern Railroad, north of Rawhide Creek.	#2	
	U.S. Highway 77, north of U.S. Highway 30/Highway 275	+1197	
	At County Road 19, north of U.S. Highway 30	+1212	
	At the intersection of County Road 17 and County Road T	+1222	
	At County Road 11, north of U.S. Highway 30	+1255	
	At Cottonwood Street, north of U.S. Highway 30	+1276	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.

ADDRESSES

City of Inglewood

Maps are available for inspection at the Inglewood Village Office, 445 Boulevard Street, Fremont, NE 68025.

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground Modified	Communities affected
City of North Bend			
Maps are available for inspection at City Hall, North Bend, NE 68649.			
Dodge County (Unincorporated Areas)			
Maps are available for inspection at Dodge County Zoning Office, 435 N. Park, Fremont, NE 68025.			
Cooke County, Texas and Incorporated Areas Docket No.: FEMA–B–7705			
Indian Creek East Lower Reach	At confluence with Lake Ray Roberts	+645	Cooke County (Unincorporated Areas).
	At Lake Kiowa Dam	+705	
Indian Creek East Tributary 1 ..	At the confluence with Indian Creek East	+645	Cooke County (Unincorporated Areas).
	Approximately 1,000 feet upstream	+693	
Indian Creek East Tributary 2 ..	At the confluence with Indian Creek East Lower Reach	+663	Cook County (Unincorporated Areas).
	Approximately 1,000 feet downstream from FM Road 3496.	+724	
Indian Creek Upper Reach	At confluence with Lake Kiowa	+705	Cooke County (Unincorporated Areas).
	Approximately 2500 feet upstream from confluence with Lake Kiowa.	+718	
Lake Kiowa	Lake Kiowa	+705	Cooke County (Unincorporated Areas).
Lake Ray Roberts	Lake Ray Roberts	+645	Cooke County. (Unincorporated Areas).
Pecan Creek North	Approximately 4,000 feet downstream from FM Road 2071.	+703	Cooke County (Unincorporated Areas).
	Approximately 2,000 feet upstream from I–35	+783	
Pecan Creek South	At the Confluence with Lake Ray Roberts	+645	City of Valley View, Cooke County (Unincorporated Areas).
	Approximately 750 feet upstream from FM Road 922	+712	
Pecan Creet South Tributary 1	At the Confluence with Pecan Creek South	+646	Cooke County (Unincorporated Areas).
	At intersection with FM Road 922	+687	
Persimmon Creek	At confluence with Elm Fork Trinity River	+645	Cooke County (Unincorporated Areas).
	Approximately 2,000 feet upstream from North Shore Drive.	+700	
Persimmon Creek Tributary 1 ..	At confluence with Persimmon Creek (Pioneer Valley Lake).	+664	Cooke County (Unincorporated Areas).
	Approximately 2,000 feet upstream from confluence with Persimmon Creek (Pioneer Valley Lake).	+689	
Persimmon Creek Tributary 2 ..	Confluence with Persimmon Creek (Pioneer Valley Lake)	+664	Cooke County (Unincorporated Areas).
	Approximately 1,500 feet upstream from confluence with Persimmon Creek (Pioneer Valley Lake).	+667	
Persimmon Creek Tributary 3 ..	At confluence with Persimmon Creek	+678	Cooke County (Unincorporated Areas).
	Approximately 1,500 feet upstream from the confluence with Persimmon Creek.	+697	
Pond Creek	Approximately 1,000 feet downstream from confluence with Pond Creek Tributary 2 (County Border).	+646	Cooke County (Unincorporated Areas).
	Approximately 1,000 feet downstream from Rail Road (County Border).	+674	
Pond Creek Tributary 1	At the confluence with Pond Creek	+646	Cooke County (Unincorporated Areas).
	Approximately 1,200 feet upstream from I–35	+705	
Pond Creek Tributary 2	At the confluence with Pond Creek Tributary	+675	Cooke County (Unincorporated Areas).
	Approximately 1,000 feet upsteam from I–35	+702	
Tributary Kiowa 1	Confluence with Lake Kiowa	+705	Cooke County (Unincorporated Areas).
	Approximately 1,200 feet upstream from confluence with Lake Kiowa.	+713	

Flooding source(s)	Location of referenced elevation	* Elevation in feet (NGVD) + Elevation in feet (NAVD) # Depth in feet above ground Modified	Communities affected
Tributary Kiowa	At confluence with Lake Kiowa	+705	Cooke County (Unincorporated Areas).
	Approximately 2,500 feet upstream from confluence with Lake Kiowa.	+723	
Wolf Creek	At the confluence with Lake Ray Roberts	+645	Cooke County (Unincorporated Areas).
	Approximately 1,000 feet upstream from FM 295	+746	
Wolf Creek Tributary 1	At the confluence with Wolf Creek	+681	Cooke County (Unincorporated Areas).
	Approximately 2,700 feet upstream from confluence with Wolf Creek.	+709	

* National Geodetic Vertical Datum.
+ North American Vertical Datum.
# Depth in feet above ground.

ADDRESSES

City of Valley View
Maps are available for inspection at 100 South Dixon, Gainesville, TX 76240.

Cooke County (Unincorporated Areas)
Maps are available for inspection at 100 South Dixon, Gainesville, TX 76240.

(Catalog of Federal Domestic Assistance No. 97.022, ''Flood Insurance.'')

Dated: June 29, 2009.

David I. Maurstad,

Federal Insurance Administrator of the National Flood Insurance Program, Department of Homeland Security, Federal Emergency Management Agency.

[FR Doc. E9–16519 Filed 7–10–09; 8:45 am]

BILLING CODE 9110–12–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 660

[Docket No. 071106669–81372–03]

RIN 0648–AU26

Fisheries Off West Coast States; Coastal Pelagic Species Fishery; Amendment 12 to the Coastal Pelagic Species Fishery Management Plan

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Final rule

SUMMARY: NMFS issues this final rule to implement Amendment 12 to the Coastal Pelagic Species (CPS) Fishery Management Plan (FMP) which would provide protection for all species of krill off the West Coast (i.e., California, Oregon and Washington). This rule would prohibit the harvest of all species of krill by any fishing vessel operating in the Exclusive Economic Zone (EEZ) off the West Coast, and would also deny the use of exempted fishing permits to allow krill fishing.

DATES: Effective August 12, 2009.

ADDRESSES: Copies of Amendment 12, which includes an Environmental Assessment/Initial Regulatory Flexibility Analysis/Regulatory Impact Review, are available from Rodney R. McInnis, Regional Administrator, Southwest Region, NMFS, 501 West Ocean Blvd., Suite 4200, Long Beach,CA 90802.

FOR FURTHER INFORMATION CONTACT: Joshua B. Lindsay, Sustainable Fisheries Division, NMFS, at 562–980–4034 or Mike Burner, Pacific Fishery Management Council, at 503–820–2280.

SUPPLEMENTARY INFORMATION: The CPS fishery in the EEZ off the West Coast is managed under the CPS FMP, which was developed by the Pacific Fishery Management Council (Council) pursuant to the Magnuson-Stevens Fishery Conservation and Management Act (Magnuson-Stevens Act). The CPS FMP was approved by the Secretary of Commerce on June 10, 1999, and was implemented by a final rule (64 FR 69888, December 15, 1999) that was codified at 50 CFR part 660, subpart I.

Amendment 12, which was approved by the Secretary of Commerce on May 25, 2007, added all species of krill as a management unit species under the CPS FMP and placed krill under a newly established ''prohibited harvest species'' category. This new category differs from the existing ''prohibited species'' definition in the FMP because ''prohibited harvest species'' may not be taken by any fishery or gear type in the U.S. EEZ. In contrast, ''prohibited species'' may not be taken and retained incidentally by CPS fishery participants, but are legally harvested under provisions in Federal regulations implementing other Council FMPs.

As the principal food source for many fish and non-fish species, krill are a critical component of the marine ecosystem. Off the West Coast krill are important prey for a variety of fish species, including several overfished groundfish species, salmon and Pacific whiting. Krill are also a principal food source for many species of marine mammals and seabirds, some of which are listed as threatened or endangered under the Endangered Species Act and warrant special efforts for protection and recovery. Although there is no indication that the status of the krill resource has contributed to the overfished, endangered, or threatened status of these species, protecting krill will help to maintain these important ecological relationships and to ensure the long-term health and productivity of the West Coast ecosystem. Amendment 12 incorporates ecosystem conservation principles into fishery management programs by protecting, to the extent

practicable, krill resources, which are an integral part of that ecosystem.

At this time, there are no Federal regulations that limit fishing for krill in the EEZ. While a krill fishery off the U.S. West Coast does not currently exist and there have been only limited expressions of interest in commercial exploitation of krill in the EEZ, NMFS is concerned such a fishery could develop, which could have an adverse impact on other West Coast fish stocks, marine mammals, seabirds and the ecosystem generally.

The states of Washington, Oregon, and California prohibit their vessels from fishing for krill and prohibit landings of krill into their respective ports. However, these prohibitions would not prevent a fishery from developing in the West Coast EEZ by vessels from outside of the region, as long as landings were not made into a West Coast port. A market for krill currently exists in Washington and Oregon, where salmon farms use krill products as a supplemental feed. Federal (EEZ) waters that lie outside of the state prohibitions on krill harvest may in the future be used for fish farming. Such future operations could use krill as feed stock, and a fishery could develop around the needs of these aquaculture facilities. Local krill would likely be a potential food source, which may significantly increase the likelihood of a krill fishery developing within West Coast EEZ waters.

NMFS is concerned about the potential impacts of a krill fishery based in part on information regarding large-scale krill fishing methods and the impacts of existing krill fisheries in other areas of the world. Krill concentrations attract aggregations of marine mammals, seabirds, and fish predators, and bycatch and/or disturbance of these organisms is likely to occur due to the trawl-type gear used to catch krill. In the Antarctic krill fishery, there is known bycatch of fur seals as well as various sea birds. In British Columbia, a krill fishery began in 1970, and quotas were established in 1976 due to concerns for harvesting a forage species upon which salmon and other commercially important finfish depend. An annual catch was set at 500 tons with an open season from November to March to minimize the incidental catch of larval and juvenile fish.

NMFS has considered the potential for development of a krill fishery and the potential impacts a fishery could have on krill resources and on the fish and other species, such as birds and mammals, that are dependent on, or that are sensitive to, the abundance and availability of krill. NMFS believes it is critical to take preventive action at this time to ensure that a krill fishery will not develop that could potentially harm krill stocks, and in turn harm other fish and non-fish stocks. In an environmental assessment prepared for this action, NMFS analyzed the option of allowing a small harvest of krill, but ultimately decided to approve the Council's recommendation to impose a simple prohibition, which is consistent with State law and easier to enforce and administer than a program allowing for low harvest levels.

Under Amendment 12, krill (all species) would be added to the management unit species of the CPS FMP. Further, a new category of management unit species – ''prohibited harvest'' – would be established under the FMP. Krill would be placed in that category. This means that optimum yield (OY) for krill would be zero, and the target, harvest and transhipment of krill would be prohibited. Also, exempted fishing permits (EFPs) would not be issued under the EFP procedures of the CPS FMP to allow individuals to harvest krill as an exception to the prohibition of harvest. These actions would fully achieve the objectives of the amendment to the extent practicable, but would not account for environmental conditions and the responses of krill and other resources to changes in environmental conditions. NMFS recognizes that *de minimis* or trace amounts of krill may be retained by fishermen while targeting other species; such inadvertent action is not intended to be the subject of this prohibition.

Four alternatives were analyzed for this action. For further background information on these alternatives and this action please refer to the Amendment 12 document entitled *Management of Krill as an Essential Component of the California Current Ecosystem*.

NMFS received thirteen comments regarding the proposed regulations to implement Amendment 12. All comments were supportive of the action.

Classification

The Administrator, Southwest Region, NMFS, determined that Amendment 12 to the CPS FMP is necessary for the conservation and management of krill and that it is consistent with the Magnuson-Stevens Fishery Conservation and Management Act and other applicable laws.

This final rule has been determined to be significant for the purposes of Executive Order 12866.

The Chief Counsel for Regulation of the Department of Commerce certified to the Chief Counsel for Advocacy of the Small Business Administration during the proposed rule stage that this action would not have a significant economic impact on a substantial number of small entities. The factual basis for the certification was published in the proposed rule and is not repeated here. No comments were received regarding

this certification or the economic impact of the proposed rule. As a result, a regulatory flexibility analysis was not required and none was prepared.

List of Subjects in 50 CFR Part 660

Fisheries, Fishing, Reporting and recordkeeping requirements.

Dated: July 7, 2009.

Samuel D. Rauch III,

Deputy Assistant Administrator For Regulatory Programs, National Marine Fisheries Service.

■ For the reasons set out in the preamble, NMFS amends 50 CFR part 660 as follows:

PART 660—FISHERIES OFF WEST COAST STATES

■ 1. The authority citation for part 660 continues to read as follows:

Authority: 16 U.S.C. 1801 *et seq.*

2. In § 660.502 the definitions of ''Krill'' and ''Prohibited harvest species'' are added in alphabetical order to read as follows:

§ 660.502 Definitions.

* * * * *

Krill means all species of euphausiids that occur in the EEZ off the West Coast.

* * * * *

Prohibited harvest species means all krill species in the EEZ off the West Coast.

* * * * *

■ 3. In § 660.505, add paragraph (o) as follows:

§ 660.505 Prohibitions.

* * * * *

(o) Fish for, target, harvest or land a prohibited harvest species in any fishery within the EEZ off the West Coast.

[FR Doc. E9–16531 Filed 7–10–09; 8:45 am]

BILLING CODE 3510–22–S

Proposed Rules

Federal Register
Vol. 74, No. 132
Monday, July 13, 2009

This section of the FEDERAL REGISTER contains notices to the public of the proposed issuance of rules and regulations. The purpose of these notices is to give interested persons an opportunity to participate in the rule making prior to the adoption of the final rules.

DEPARTMENT OF AGRICULTURE

Food Safety and Inspection Service

9 CFR Part 381

[Docket No. FSIS–2007–0048]

RIN 0583–AC83

Classes of Poultry

AGENCY: Food Safety and Inspection Service, USDA.

ACTION: Supplemental notice of proposed rulemaking.

SUMMARY: The Food Safety and Inspection Service (FSIS) is providing new information on, and re-proposing the definition and standard for, ''roaster'' and ''roasting chicken.'' FSIS proposed this definition and standard in its September 29, 2003, proposed rule to amend the definitions and standards for the official U.S. classes of poultry. After the proposed rule was published, FSIS received from the U.S. Department of Agriculture's (USDA's) Agricultural Marketing Service (AMS) new information that would affect the definition and standard for ''roaster'' or ''roasting chicken.'' FSIS has tentatively concluded that it should re-propose this definition and standard but no others in the proposed rule.

DATES: Comments must be received on or before August 12, 2009.

ADDRESSES: FSIS invites interested persons to submit comments on this proposed rule. Comments may be submitted by either of the following methods:

- *Federal eRulemaking Portal:* This Web site provides the ability to type short comments directly into the comment field on this Web page or attach a file for lengthier comments. Go to *http://www.regulations.gov*. Follow the online instructions at that site for submitting comments.
- *Mail, including floppy disks or CD-ROMs, and hand- or courier-delivered items:* Send to Docket Clerk, USDA, FSIS, Room 2–2127 George Washington Carver Center, 5601 Sunnyside Avenue, Beltsville, MD 20705.

Instructions: All items submitted by mail or electronic mail must include the Agency name and docket number FSIS–2007–0048. Comments received in response to this docket will be made available for public inspection and posted without change, including any personal information, to *http://www.regulations.gov*.

Docket: For access to background documents or comments received, go to the FSIS Docket Room at the address listed above between 8:30 a.m. and 4:30 p.m., Monday through Friday.

FOR FURTHER INFORMATION CONTACT: Director, FSIS Labeling and Program Delivery Division, *Phone:* (301) 504–0878, *Fax:* (301) 504–0872.

SUPPLEMENTARY INFORMATION:

Background

The Poultry Products Inspection Act (PPIA) prohibits the distribution of poultry products that are adulterated or misbranded (21 U.S.C. 458). The PPIA also authorizes the Secretary of Agriculture to prescribe, among other things, definitions and standards of identity or composition for poultry products whenever the Secretary determines that such action is necessary for the protection of the public (21 U.S.C. 457(b)). Poultry classes were established by USDA to aid in labeling poultry. The classes were based primarily on the age and sex of the bird. FSIS uses poultry class standards to ensure that poultry products are labeled in a truthful and non-misleading manner.

Before publishing the 2003 proposal, FSIS reviewed the poultry class definitions with AMS's Poultry Programs, and both agencies discussed the definitions and standards with members of the poultry industry and others knowledgeable about poultry genetics and breeding. After examining poultry production methods and reviewing the poultry classes defined in 9 CFR 381.170, FSIS and AMS determined that several poultry class definitions and standards did not reflect poultry characteristics or industry practices. As a result, FSIS and AMS determined that the poultry class definitions needed to be revised to more accurately and clearly describe poultry being marketed and to ensure that the labels for poultry products are not false or misleading.

FSIS proposed to lower the age definitions for six classes of poultry (68 FR 55902), including reducing the age of ''roaster'' or ''roasting chicken'' from 3 to 5 months to less than 12 weeks (*see* 9 CFR 381.170(a)(1)(iv)). FSIS also solicited comments regarding the merit of establishing ready-to-cook (RTC) carcass weights or maximums for poultry classes (including the ''roaster'' or ''roasting chicken''). FSIS did not propose to include a RTC carcass weight in the ''roaster'' or ''roasting chicken'' class definition. FSIS asked commenters to provide a factual basis for or against the establishment of weight requirements.

After the comment period closed, AMS provided FSIS with data that suggest that FSIS should include a RTC carcass weight in the definition of ''roaster'' and change the proposed weeks of age in that definition. AMS surveyed the segment of the industry that routinely produces ''roasters'' and obtained data on target weights from 8 of the 13 ''roaster'' suppliers. Based on these data, AMS has recommended that a ''roaster'' be defined as a chicken from 8 to 12 weeks of age and with a RTC carcass weight of 5 pounds or more. These AMS survey data are available for public inspection in the FSIS Docket Clerk's Office, USDA, FSIS, Room 2–2127 George Washington Carver Center, 5601 Sunnyside Avenue, Beltsville, MD 20705, between 8:30 a.m. and 4:30 p.m., Monday through Friday.

Comments on Establishing Maximum Weights and the Age for the ''Roaster'' Class

Several commenters from industry suggested a ''roaster'' be a chicken that is between the age of 60 days and 85 days at the time of slaughter from a flock that has an average live weight of 7.75 pounds or more. A commenter from industry suggested age definitions for a ''roaster'' should be between 9 and 12 weeks of age at the time of processing. This commenter also recommended that ''roasters'' come from a flock with an average daily flock weight of 8 pounds, at minimum. Also, two commenters from industry were concerned that the proposed age definition of ''less than 12 weeks'' will allow large broilers to be classified as ''roasters''. Another industry commenter

recommended allowing the roaster class to include broilers, as long as the product meets weight requirements for roasters. One commenter opposed including RTC carcass weights in the definitions and standards. This commenter stated that including RTC carcass weights will lead to further abuse of chickens.

On the basis of AMS data, FSIS has tentatively concluded that a ''roaster'' or ''roasting chicken'' should be defined as a chicken from 8–12 weeks of age. Most of the comments supported use of this age range for roasters. By including the RTC carcass weight for this class of poultry, the standard and definition should effectively differentiate ''roasters'' and ''broilers''.

FSIS has tentatively concluded that a ''roaster'' or ''roasting chicken'' should be defined as a chicken with an RTC carcass weight of 5 pounds or more, based on recent survey information from AMS. In addition, FSIS has tentatively concluded that RTC carcass weight, instead of average live weight, is necessary in the class standard and definition so that FSIS can verify the appropriate use of the term ''roaster'' or ''roasting chicken'' on product labels.

Executive Orders 12866 and 12988, Regulatory Flexibility Act, and Paperwork Requirements

This proposed rule has been determined to be not significant and was reviewed by the Office of Management and Budget under Executive Order 12866.

The changes FSIS is proposing to the definition of ''roaster'' or ''roasting chicken'' do not affect the Executive Order 12866 analysis (68 FR 55903) or the Regulatory Flexibility Analysis (68 FR 55904). Similarly, the changes do not affect paperwork requirements (68 FR 55904) or review of the rule under Executive Order 12988.

Additional Public Notification

Public awareness of all segments of rulemaking and policy development is important. Consequently, in an effort to ensure that minorities, women, and persons with disabilities are aware of this proposed rule, FSIS will announce it online through the FSIS Web page located at *http://www.fsis.usda.gov/regulations_policies/regulations_directives_notices/index.asp*.

FSIS will also make copies of this **Federal Register** publication available through the FSIS Constituent Update, which is used to provide information regarding FSIS policies, procedures, regulations, **Federal Register** notices, FSIS public meetings, and other types of information that could affect or would be of interest to constituents and stakeholders. The Update is communicated via Listserv, a free electronic mail subscription service for industry, trade groups, consumer interest groups, health professionals, and other individuals who have asked to be included. The Update is also available on the FSIS Web page. Through the Listserv and Web page, FSIS is able to provide information to a much broader and more diverse audience. In addition, FSIS offers an electronic mail subscription service which provides automatic and customized access to selected food safety news and information. This service is available at *http://www.fsis.usda.gov/news_and_events/email_subscription/*.

Options range from recalls to export information to regulations, directives and notices. Customers can add or delete subscriptions themselves, and have the option to password protect their accounts.

List of Subjects in 9 CFR Part 381

Food grades and standards, Poultry and poultry products.

For the reasons set forth in the preamble, FSIS proposed to further amend 9 CFR Part 381, as previously proposed to be amended on September 29, 2003 (68 FR 55902):

PART 381—POULTRY PRODUCTS INSPECTION REGULATIONS

1. The authority citation for part 381 continues to read as follows:

Authority: 7 U.S.C. 138f; 7 U.S.C. 450; 21 U.S.C. 451–470; 7 CFR 2.18, 2.53.

§ 381.170 Standards for kinds and classes, and for cuts of raw poultry.

2. Section 381.170 would be amended by revising paragraph (a)(1)(iii) to read as follows:

§ 381.170 Standards for kinds and classes, and for cuts of raw poultry.

(a) * * *

(1) * * *

(iii) *Roaster or roasting chicken.* A ''roaster'' or ''roasting chicken'' is a young chicken from 8 to 12 weeks of age, of either sex, with a ready-to-cook carcass weight of 5 pounds or more, that is tender-meated with soft, pliable, smooth-textured skin and breastbone cartilage that is somewhat less flexible than that of a broiler or fryer.

* * * * *

Done at Washington, DC, on July 7, 2009.

Alfred V. Almanza,

Administrator.

[FR Doc. E9–16402 Filed 7–10–09; 8:45 am]

BILLING CODE 3410–DM–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 25

[Docket No. NM408; Notice No. 25–09–04–SC]

Special Conditions: Alenia Model C–27J Airplane; Liquid Oxygen System

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed special conditions.

SUMMARY: This action proposes special conditions for the Alenia Model C–27J airplane. This airplane will have novel or unusual design features when compared to the state of technology described in the airworthiness standards for transport-category airplanes. These design features include a liquid-oxygen (LOX) system. The applicable airworthiness regulations do not contain adequate or appropriate safety standards for oxygen systems that use liquid oxygen. These proposed special conditions contain the additional safety standards that the Administrator considers necessary to establish a level of safety equivalent to that established by the existing airworthiness standards.

DATES: We must receive your comments by August 12, 2009.

ADDRESSES: You must mail two copies of your comments to: Federal Aviation Administration, Transport Airplane Directorate, *Attn:* Rules Docket (ANM–113), Docket No. NM408, 1601 Lind Avenue, SW., Renton, Washington, 98057–3356. You may deliver two copies to the Transport Airplane Directorate at the above address. You must mark your comments: Docket No. NM408. You can inspect comments in the Rules Docket weekdays, except Federal holidays, between 7:30 a.m. and 4 p.m.

FOR FURTHER INFORMATION CONTACT: Holly Thorson, FAA, International Branch, ANM–116, Transport Airplane Directorate, Aircraft Certification Service, 1601 Lind Avenue, SW., Renton, Washington 98057–3356; telephone (425) 227–1357, facsimile (425) 227–1149.

SUPPLEMENTARY INFORMATION:

Comments Invited

We invite interested people to take part in this rulemaking by sending written comments, data, or views. The most helpful comments reference a specific portion of the special conditions, explain the reason for any recommended change, and include supporting data. We ask that you send us two copies of written comments.

We will file in the docket all comments we receive, as well as a report summarizing each substantive public contact with FAA personnel concerning these special conditions. You can inspect the docket before and after the comment closing date. If you wish to review the docket in person, go to the address in the **ADDRESSES** section of this preamble between 7:30 a.m. and 4 p.m., Monday through Friday, except Federal holidays.

We will consider all comments we receive on or before the closing date for comments. We will consider comments filed late if it is possible to do so without incurring expense or delay. We may change these special conditions based on the comments we receive.

If you want the FAA to acknowledge receipt of your comments on this proposal, include with your comments a self-addressed, stamped postcard on which the docket number appears. We will stamp the date on the postcard and mail it back to you.

Background

On March 27, 2006, the European Aviation Safety Agency (EASA) forwarded to the FAA an application from Alenia Aeronautica of Torino, Italy, for U.S. type certification of a twin-engine commercial transport designated as the Model C–27J. The C–27J is a twin-turbopropeller, cargo-transport aircraft with a maximum takeoff weight of 30,500 kilograms.

Type Certification Basis

Under the provisions of § 21.17 of Title 14 Code of Federal Regulation (14 CFR) and the bilateral agreement between the U.S. and Italy, Alenia Aeronautica must show that the C–27J meets the applicable provisions of 14 CFR part 25, as amended by Amendments 25–1 through 25–87. Alenia also elects to comply with Amendment 25–122, effective September 5, 2007, for 14 CFR 25.1317.

If the Administrator finds that existing airworthiness regulations do not adequately or appropriately address safety standards for the C–27J due to a novel or unusual design feature, we prescribe special conditions under provisions of 14 CFR 21.16.

In addition to the applicable airworthiness regulations and special conditions, the C–27J must comply with the fuel-vent and exhaust-emission requirements of 14 CFR part 34 and the noise-certification requirements of 14 CFR part 36, and the FAA must issue a finding of regulatory adequacy pursuant to section 611 of Public Law 92–574, the ''Noise Control Act of 1972.''

The FAA issues special conditions, under §§ 11.19 and 11.38, and they become part of the type-certification basis under § 21.17(a)(2).

Special conditions are initially applicable to the model for which they are issued. Should the type certificate for that model be amended later to include any other model that incorporates the same or similar novel or unusual design feature, the special conditions also apply to the other model under § 21.101.

Novel or Unusual Design Features

The Alenia Model C–27J incorporates a liquid-oxygen system, including a liquid-oxygen converter, valves, evaporating coils, lines, regulators, indicators, fittings, etc. The existing airworthiness regulations do not adequately or appropriately address safety standards for the design and installation of oxygen systems that utilize liquid oxygen. These proposed special conditions for the C–27J contain the additional safety standards that the Administrator considers necessary to establish a level of safety equivalent to that established by the existing airworthiness standards for these novel or unusual design features.

Discussion

There are no specific regulations that address the design and installation of oxygen systems that utilize liquid oxygen for storage. Existing requirements, such as §§ 25.1309, 25.1441(b) and (c), 25.1451, and 25.1453, in the Alenia C–27J certification basis, provide some design standards for crew and medical-oxygen-system installations. However, additional design standards for oxygen systems utilizing liquid oxygen are needed to supplement the existing applicable requirements. The quantity of liquid oxygen involved in this installation and the potential for unsafe conditions that may result when the oxygen content of an enclosed area becomes too high because of system leaks, malfunction, or damage from external sources, make it necessary to assure adequate safety standards are applied to the design and installation of the system in Alenia C–27J airplanes. These proposed special conditions require Alenia to preclude or minimize the risk of these potential unsafe conditions. These proposed special conditions are also intended to assure the safe operation of the liquid-oxygen system, and therefore require that:

- Adequate gaseous oxygen is available at temperatures appropriate for breathing;
- The liquid-oxygen converter and gaseous-oxygen-distribution lines are installed in locations that minimize their potential for damage;
- The quantity of available oxygen is clearly indicated to the flight crew;
- The system is designed to prevent leakage of oxygen into the cabin;
- Condensation from the system is collected and drained overboard;
- The system must be protected from possible ignition sources and structural damage; and
- Appropriate maintenance and operational instructions are provided to ensure the system's safe operation.

Taken together, these requirements would ensure that this liquid-oxygen system provides an equivalent level of safety to traditional oxygen systems.

Applicability

As discussed above, these proposed special conditions are applicable to the Alenia C–27J. Should Alenia apply at a later date for a change to the type certificate to include another airplane model incorporating the same novel or unusual design features, these proposed special conditions apply to that model as well under § 21.101.

Conclusion

This action affects only certain novel or unusual design features of the Alenia C–27J. It is not a rule of general applicability, and it affects only the applicant that applied to the FAA for approval of these features on the airplane.

List of Subjects in 14 CFR Part 25

Aircraft, Aviation safety, Reporting and recordkeeping requirements.

The authority citation for these special conditions is as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701, 44702, 44704.

The Proposed Special Conditions

Accordingly, the Administrator of the Federal Aviation Administration (FAA) proposes the following special conditions as part of the type-certification basis for the C–27J.

General

1. The liquid-oxygen system must be located to minimize the possibility of

exposure of occupants to liquid oxygen from a leak or condensation.

2. The liquid-oxygen converter must be located in the airplane so that there is no risk of damage to the converter due to an uncontained rotor or propeller-blade failure.

3. The liquid-oxygen system's associated gaseous-oxygen-distribution lines should be designed and located to minimize the hazard from uncontained rotor or propeller-blade debris.

4. The flight-deck oxygen system must meet the supply requirements of Part 121 in the event the oxygen-distribution line is severed by a rotor or propeller-blade fragment.

5. The pressure-relief valves on the liquid-oxygen converters must be vented overboard. The ventilation means must be configured such that liquid and gaseous oxygen will be exhausted so that oxygen will not accumulate inside the airplane. Means must be provided to prevent hydrocarbon-fluid migration from impinging upon the vent outlet of the liquid-oxygen system.

6. The system must include provisions to ensure complete conversion of the liquid oxygen to gaseous oxygen. The resultant oxygen gas must be delivered to the first oxygen outlet for breathing such that the temperature is no more than 35 °F less than the cabin ambient temperature or 32 °F (whichever is greater), under the conditions of the maximum demand or flow of oxygen gas for normal use of the oxygen system. A liquid-oxygen shutoff valve must be installed on the main oxygen-distribution line prior to any secondary lines. The shutoff valve must be both compatible with liquid-oxygen temperatures and readily accessible (either directly if manual, or by remote activation if automatic).

7. If multiple converters are used, the design should ensure that a leak in one converter does not result in leakage of oxygen from any other converter.

8. Approved flexible hoses must be used for the airplane-systems connections to shock-mounted converters, where movement relative to the airplane may occur.

9. Condensation from system components or lines must be collected by drip pans, shields, or other suitable collection means, and drained overboard through a drain fitting separate from the liquid-oxygen vent fitting, as specified in special condition 5, above.

10. Oxygen-system components must be burst-pressure tested to 3.0 times, and proof-pressure tested to 1.5 times, the maximum normal operating pressure. Compliance with the requirement for burst testing may be shown by similarity analysis, or a combination of similarity analysis and test.

11. Oxygen-system components must be electrically bonded to the airplane structure.

12. All gaseous or liquid-oxygen connections located in close proximity to an ignition source must be shrouded and vented overboard using the system specified in special condition 5, above.

13. A means must be provided to indicate to the flight crew the quantity of available oxygen.

14. Instructions for Continued Airworthiness (ICA) per § 25.1529 must be provided for the safe operation and maintenance of the liquid-oxygen system.

15. Emergency procedures must be developed for the aircraft crew to address aircraft-safety-related malfunctions of the liquid-oxygen system.

16. The liquid-oxygen-system equipment, including the tank, must be retained under all loads up to those specified in § 25.561(b)(3). The tank must be able to resist rupture and to retain the liquid oxygen, under the inertia forces prescribed for the emergency-landing conditions in § 25.561. In addition, the tank must be able to withstand, without failure, the vibration, inertia, fluid, and structural loads that it may be subjected to in operation. The liquid-oxygen components, including the tank, must be protected from scraping or impact from baggage, cargo, or other contents.

Issued in Renton, Washington, on July 7, 2009.

Stephen P. Boyd,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. E9–16504 Filed 7–10–09; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. FAA–2009–0607; Directorate Identifier 2009–NM–024–AD]

RIN 2120–AA64

Airworthiness Directives; Boeing Model 747–100B SUD, 747–200B, 747–300, 747–400, and 747–400D Series Airplanes

AGENCY: Federal Aviation Administration (FAA), Department of Transportation (DOT).

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: The FAA proposes to supersede an existing airworthiness directive (AD) that applies to all Boeing Model 747–100B SUD, 747–300, 747–400, and 747–400D series airplanes; and Model 747–200B series airplanes having a stretched upper deck. The existing AD currently requires repetitively inspecting for cracking or discrepancies of the fasteners in the tension ties, shear webs, and frames at body stations 1120 through 1220; and related investigative and corrective actions if necessary. This proposed AD would also require modifying the frame-to-tension-tie joints at body stations 1120 through 1220 (including related investigative actions and corrective actions if necessary), which would provide a terminating action for the repetitive inspections. This proposed AD would also require new repetitive inspections after the modification, corrective actions if necessary, and additional modification requirements at a specified time after the first modification. This proposed AD would also remove certain airplanes from the applicability. This proposed AD results from reports of cracked and severed tension ties, broken fasteners, and cracks in the frame, shear web, and shear ties adjacent to tension ties for the upper deck. We are proposing this AD to detect and correct cracking of the tension ties, shear webs, and frames of the upper deck, which could result in rapid decompression and reduced structural integrity of the airplane.

DATES: We must receive comments on this proposed AD by August 27, 2009.

ADDRESSES: You may send comments by any of the following methods:

- *Federal eRulemaking Portal:* Go to *http://www.regulations.gov*. Follow the instructions for submitting comments.
- *Fax:* 202–493–2251.
- *Mail:* U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue, SE., Washington, DC 20590.
- *Hand Delivery:* U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue, SE., Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays.

For service information identified in this proposed AD, contact Boeing Commercial Airplanes, Attention: Data & Services Management, P.O. Box 3707, MC 2H–65, Seattle, Washington 98124–2207; telephone 206–544–5000, extension 1; fax 206–766–5680; e-mail *me.boecom@boeing.com*; Internet

https://www.myboeingfleet.com. You may review copies of the referenced service information at the FAA, Transport Airplane Directorate, 1601 Lind Avenue, SW., Renton, Washington. For information on the availability of this material at the FAA, call 425–227–1221 or 425–227–1152.

Examining the AD Docket

You may examine the AD docket on the Internet at *http://www.regulations.gov*; or in person at the Docket Management Facility between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The AD docket contains this proposed AD, the regulatory evaluation, any comments received, and other information. The street address for the Docket Office (telephone 800–647–5527) is in the **ADDRESSES** section. Comments will be available in the AD docket shortly after receipt.

FOR FURTHER INFORMATION CONTACT: Ivan Li, Aerospace Engineer, Airframe Branch, ANM–120S, FAA, Seattle Aircraft Certification Office, 1601 Lind Avenue, SW., Renton, Washington 98057–3356; telephone (425) 917–6437; fax (425) 917–6590.

SUPPLEMENTARY INFORMATION:

Comments Invited

We invite you to send any written relevant data, views, or arguments about this proposed AD. Send your comments to an address listed under the **ADDRESSES** section. Include ''Docket No. FAA–2009–0607; Directorate Identifier 2009–NM–024–AD'' at the beginning of your comments. We specifically invite comments on the overall regulatory, economic, environmental, and energy aspects of this proposed AD. We will consider all comments received by the closing date and may amend this proposed AD because of those comments.

We will post all comments we receive, without change, to *http://www.regulations.gov*, including any personal information you provide. We will also post a report summarizing each substantive verbal contact we receive about this proposed AD.

Discussion

On November 15, 2007, we issued AD 2007–23–18, amendment 39–15266 (72 FR 65655, November 23, 2007), for all Boeing Model 747–100B SUD, 747–300, 747–400, and 747–400D series airplanes; and Model 747–200B series airplanes having a stretched upper deck. That AD requires repetitively inspecting for cracking or discrepancies of the fasteners in the tension ties, shear webs, and frames at body stations 1120 through 1220; and related investigative and corrective actions if necessary. That AD resulted from reports of multiple severed adjacent tension ties, in addition to the previous reports of cracked and severed tension ties, broken fasteners, and cracks in the frame, shear web, and shear ties adjacent to tension ties for the upper deck. We issued that AD to detect and correct cracking of the tension ties, shear webs, and frames of the upper deck, which could result in rapid decompression and reduced structural integrity of the airplane.

Actions Since Existing AD Was Issued

In AD 2007–23–18, we required inspection reports because the extent of cracking in the fleet was not known, and we specified that the inspection reports would help determine the damage condition of the fleet. We stated that, based on the results of those reports, we might determine that further corrective action is warranted. Since we issued that AD, the manufacturer has developed a new modification that would terminate the repetitive Stage 1 and Stage 2 inspections required by paragraphs (f) and (i) of AD 2007–23–18. Therefore, further corrective action is warranted; however, this proposed AD does not provide a terminating action for all repetitive inspections.

Boeing has also informed us that Model 747–400 airplanes converted to the 747–400 LCF (large cargo freighter) configuration (airplanes having variable numbers RT631, RT632, RT743, and RT876) no longer have the affected tension ties and, therefore, are not subject to the unsafe condition. These airplanes are no longer included in the effectivity of Boeing Alert Service Bulletin 747–53A2559, dated January 8, 2009, described below.

Relevant Service Information

We have reviewed Boeing Alert Service Bulletin 747–53A2559, dated January 8, 2009. The service bulletin describes procedures for modifying the frame-to-tension-tie joints at body stations 1120 through 1220. The modification includes installing a new frame and tension tie structure outboard of approximately buttock line 36, related investigative actions, and corrective actions if necessary. The related investigative actions include a detailed inspection for cracking of the remaining frame structure and tension tie structure and an open-hole high frequency eddy current inspection for cracking of the fastener holes opened during the modification. The corrective actions include contacting Boeing for repair instructions. The service bulletin also describes procedures for repetitive post-modification detailed inspections for cracking from body stations 1120 through 1220. For airplanes on which any crack is found, the service bulletin specifies the corrective action of contacting Boeing for repair instructions. The service bulletin also specifies contacting Boeing for additional modification requirements at a specified time after doing the initial modification.

Modifying the frame-to-tension-tie joints at body stations 1120 through 1220 eliminates the need for the repetitive Stage 1 and Stage 2 inspection requirements of AD 2007–23–18.

The compliance times in Boeing Alert Service Bulletin 747–53A2559, dated January 8, 2009, are:

- For the initial modification: Before the accumulation of 17,000 total flight cycles, or within 3,000 flight cycles after the date on the service bulletin, whichever occurs later.
- For the repetitive post-modification detailed inspections: Within 8,000 flight cycles after the modification, or within 1,000 flight cycles after the date on the service bulletin, whichever occurs later; and repeated thereafter at intervals not to exceed 3,000 flight cycles.
- For repair of any crack: Before further flight after finding the crack. The inspection is repeated thereafter at intervals not to exceed 3,000 flight cycles.
- For the additional modification requirements: Before the accumulation of 14,000 flight cycles after the first modification, or within 1,000 flight cycles after the date on the service bulletin, whichever occurs later.

FAA's Determination and Requirements of the Proposed AD

We have evaluated all pertinent information and identified an unsafe condition that is likely to develop on other airplanes of the same type design. For this reason, we are proposing this AD, which would supersede AD 2007–23–18 and would retain the requirements of the existing AD. This proposed AD would also require accomplishing the actions specified in the service bulletin described previously, except as discussed under ''Difference Between the Proposed AD and the Service Information.''

Difference Between the Proposed AD and the Service Information

The service bulletin specifies to contact the manufacturer for instructions on how to repair certain conditions, but this proposed AD would require repairing those conditions in one of the following ways:

- Using a method that we approve; or

• Using data that meet the certification basis of the airplane, and that have been approved by an Authorized Representative for the Boeing Commercial Airplanes Delegation Option Authorization Organization whom we have authorized to make those findings.

Related Rulemaking

On December 26, 2007, we issued AD 2004–07–22 R1, amendment 39–15326 (73 FR 1052, January 7, 2008), which is applicable to all Boeing Model 747–100, 747–100B, 747–100B SUD, 747–200B, 747–200C, 747–200F, 747–300, 747–400, 747–400D, 747–400F, 747SR, and 747SP series airplanes. (A correction to AD 2004–07–22 R1 was published in the **Federal Register** on February 14, 2008 (73 FR 8589).) That AD requires that the maintenance inspection program be revised to include inspections that will give no less than the required damage tolerance rating for each structural significant item, and repair of cracked structure. That AD resulted from a report of incidents involving fatigue cracking in transport category airplanes that are approaching or have exceeded their design service objective. We issued that AD to ensure the continued structural integrity of the affected airplanes. The repair and modification procedures of Boeing Alert Service Bulletin 747–53A2559, dated January 8, 2009, are alternative methods of compliance (AMOCs) for paragraphs (h), (i), and (j) of AD 2004–07–22 R1, only for the areas modified as given in the alert service bulletin.

On August 2, 2007, we issued AD 2007–16–19, amendment 39–15158 (72 FR 45151, August 13, 2007), which is applicable to certain Boeing Model 747–200B, 747–300, and 747–400 series airplanes. That AD requires repetitive detailed inspections for cracking of the aft tension tie channels from body station (BS) 1120 to BS 1220 and from BS 880 to BS 1100, and corrective actions if necessary. That AD resulted from cracks found in the aft tension tie channels at four station locations on a Model 747–200B series airplane that had been modified to a special freighter. We issued that AD to detect and correct cracking of the aft tension tie channels; failure of more than one tension tie could result in rapid depressurization of the airplane. The applicable inspection, repair, and modification procedures of Boeing Alert Service Bulletin 747–53A2559, dated January 8, 2009, are AMOCs for paragraph (f) of AD 2007–16–19, only for the areas modified as given in the alert service bulletin.

Changes to Existing AD

This proposed AD would retain the requirements of AD 2007–23–18. Since AD 2007–23–18 was issued, the AD format has been revised, and certain paragraphs have been rearranged. As a result, the corresponding paragraph identifiers have changed in this proposed AD, as listed in the following table:

REVISED PARAGRAPH IDENTIFIERS

Requirement in AD 2007–23–18	Corresponding requirement in this proposed AD
paragraph (f)	paragraph (g).
paragraph (g)	paragraph (h).
paragraph (h)	paragraph (i).
paragraph (i)	paragraph (j).
paragraph (j)	paragraph (k).
paragraph (k)	paragraph (l).

We have removed paragraph (b)(2) of AD 2007–23–18. Global AMOC approval has been previously given to Boeing for AD 2004–07–22 R1. Therefore, that paragraph is no longer necessary.

Interim Action

We consider this proposed AD interim action. If final action is later identified, we might consider further rulemaking then.

Costs of Compliance

There are about 618 airplanes of the affected design in the worldwide fleet, which includes 72 U.S.-registered airplanes. The following table provides the estimated costs for U.S. operators to comply with this proposed AD. The average labor rate is $80 per work hour.

ESTIMATED COSTS

Action	Work hours	Parts	Cost per airplane	Fleet cost
Stage 1 inspections (required by AD 2007–23–18)	19	$0	$1,520 per inspection cycle.	$109,440 per inspection cycle.
Stage 2 inspections (required by AD 2007–23–18)	83	$0	$6,640	$478,080 per inspection cycle.
Modification (new proposed action)	257 to 263	$341,334 to $345,490.	$361,894 to $366,530	$26,056,368 to $26,390,160.[1]
Post-modification inspections (new proposed action)	6	$0	$480 per inspection cycle	$34,560 per inspection cycle.

[1] Depending on airplane configuration.

Because the manufacturer has not yet specified the additional modification actions commensurate with the additional modification specified by this proposed AD, we cannot provide specific information regarding the required number of work hours or the cost of parts to do the proposed additional modification. Additional modification costs will likely vary depending on the operator and the airplane configuration.

Authority for This Rulemaking

Title 49 of the United States Code specifies the FAA's authority to issue rules on aviation safety. Subtitle I, Section 106, describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the Agency's authority.

We are issuing this rulemaking under the authority described in Subtitle VII, Part A, Subpart III, Section 44701, ''General requirements.'' Under that section, Congress charges the FAA with promoting safe flight of civil aircraft in air commerce by prescribing regulations for practices, methods, and procedures the Administrator finds necessary for safety in air commerce. This regulation is within the scope of that authority because it addresses an unsafe condition that is likely to exist or develop on products identified in this rulemaking action.

Regulatory Findings

We have determined that this proposed AD would not have federalism implications under Executive Order 13132. This proposed AD would not have a substantial direct effect on the States, on the relationship between the national Government and the States, or on the distribution of power and responsibilities among the various levels of government.

For the reasons discussed above, I certify that the proposed regulation:

1. Is not a ''significant regulatory action'' under Executive Order 12866;

2. Is not a ''significant rule'' under the DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and

3. Will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

We prepared a regulatory evaluation of the estimated costs to comply with this proposed AD and placed it in the AD docket. See the **ADDRESSES** section for a location to examine the regulatory evaluation.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

The Proposed Amendment

Accordingly, under the authority delegated to me by the Administrator, the FAA proposes to amend 14 CFR part 39 as follows:

PART 39—AIRWORTHINESS DIRECTIVES

1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701.

§ 39.13 [Amended]

2. The FAA amends § 39.13 by removing amendment 39–15266 (72 FR 65655, November 23, 2007) and adding the following new AD:

Boeing: Docket No. FAA–2009–0607; Directorate Identifier 2009–NM–024–AD.

Comments Due Date

(a) The FAA must receive comments on this AD action by August 27, 2009.

Affected ADs

(b) This AD supersedes AD 2007–23–18.

Applicability

(c) This AD applies to Boeing Model 747–100B SUD, 747–200B, 747–300, 747–400, and 747–400D series airplanes AD, certificated in any category, as identified in Boeing Alert Service Bulletin 747–53A2559, dated January 8, 2009.

Subject

(d) Air Transport Association (ATA) of America Code 53: Fuselage.

Unsafe Condition

(e) This AD results from reports of cracked and severed tension ties, broken fasteners, and cracks in the frame, shear web, and shear ties adjacent to tension ties for the upper deck. The Federal Aviation Administration is issuing this AD to detect and correct cracking of the tension ties, shear webs, and frames of the upper deck, which could result in rapid decompression and reduced structural integrity of the airplane.

Compliance

(f) You are responsible for having the actions required by this AD performed within the compliance times specified, unless the actions have already been done.

Restatement of the Requirements of AD 2007–23–18

Repetitive Stage 1 Inspections

(g) Do detailed inspections for cracking or discrepancies of the fasteners in the tension ties, shear webs, and frames at body stations 1120 through 1220, and related investigative and corrective actions as applicable, by doing all actions specified in and in accordance with ''Stage 1 Inspection'' of the Accomplishment Instructions of Boeing Alert Service Bulletin 747–53A2507, dated April 21, 2005, except as provided by paragraph (k) of this AD. Do the Stage 1 inspections at the applicable times specified in paragraphs (h) and (i) of this AD, except as provided by paragraphs (g)(1) and (g)(2) of this AD. All applicable related investigative and corrective actions must be done before further flight. Doing the modification required by paragraph (m) of this AD terminates the repetitive inspection requirements of this paragraph.

(1) Where paragraph 1.E., ''Compliance,'' of Boeing Alert Service Bulletin 747–53A2507, dated April 21, 2005, specifies a compliance time relative to the original issue date of the service bulletin, this AD requires compliance before the specified compliance time after April 26, 2006 (the effective date of AD 2006–06–11, amendment 39–14520, which was superseded by AD 2007–23–18).

(2) For any airplane that reaches the applicable compliance time for the initial Stage 2 inspection (as specified in Table 1, Compliance Recommendations, under paragraph 1.E. of Boeing Alert Service Bulletin 747–53A2507, dated April 21, 2005) before reaching the applicable compliance time for the initial Stage 1 inspection: Accomplishment of the initial Stage 2 inspection eliminates the need to do the Stage 1 inspections.

Compliance Time for Initial Stage 1 Inspection

(h) Do the initial Stage 1 inspection at the earlier of the times specified in paragraphs (h)(1) and (h)(2) of this AD.

(1) At the earlier of the times specified in paragraphs (h)(1)(i) and (h)(1)(ii) of this AD.

(i) At the applicable time specified in paragraph 1.E., ''Compliance,'' of Boeing Alert Service Bulletin 747–53A2507, dated April 21, 2005.

(ii) Before the accumulation of 10,000 total flight cycles, or within 250 flight cycles after November 28, 2007 (the effective date of AD 2007–23–18), whichever occurs later.

(2) At the later of the times specified in paragraphs (h)(2)(i) and (h)(2)(ii) of this AD.

(i) Before the accumulation of 12,000 total flight cycles.

(ii) Within 50 flight cycles or 20 days, whichever occurs first, after November 28, 2007.

Compliance Times for Repetitive Stage 1 Inspections

(i) Repeat the Stage 1 inspection specified in paragraph (g) of this AD at the time specified in paragraph (i)(1) or (i)(2), as applicable. Repeat the inspection thereafter at intervals not to exceed 250 flight cycles, until the initial Stage 2 inspection required by paragraph (j) of this AD has been done.

(1) For airplanes on which the initial Stage 1 inspection had not been accomplished as of November 28, 2007: Do the next inspection before the accumulation of 10,000 total flight cycles, or within 250 flight cycles after the initial Stage 1 inspection done in accordance with paragraph (g) of this AD, whichever occurs later.

(2) For airplanes on which the initial Stage 1 inspection had been accomplished as of November 28, 2007: Do the next inspection at the applicable time specified in paragraph (i)(2)(i) or (i)(2)(ii) of this AD.

(i) For airplanes that had accumulated fewer than 12,000 total flight cycles as of November 28, 2007: Do the next inspection before the accumulation of 10,000 total flight cycles, or within 250 flight cycles after November 28, 2007, whichever occurs later.

(ii) For airplanes that had accumulated 12,000 total flight cycles or more as of the effective date of this AD: Do the next inspection at the later of the times specified in paragraphs (i)(2)(ii)(A) and (i)(2)(ii)(B) of this AD.

(A) Within 250 flight cycles after accomplishment of the initial Stage 1 inspection.

(B) Within 50 flight cycles or 20 days, whichever occurs first, after November 28, 2007.

Repetitive Stage 2 Inspections

(j) Do detailed and high frequency eddy current inspections for cracking or discrepancies of the fasteners in the tension ties, shear webs, and frames at body stations 1120 through 1220, and related investigative and corrective actions as applicable, by doing all actions specified in and in accordance with ''Stage 2 Inspection'' of the Accomplishment Instructions of Boeing Alert Service Bulletin 747–53A2507, dated April 21, 2005, except as provided by paragraph (k) of this AD. Do the initial and repetitive Stage 2 inspections at the applicable times specified in paragraph 1.E., ''Compliance,'' of Boeing Alert Service Bulletin 747–53A2507, dated April 21, 2005. All applicable related investigative and corrective actions must be done before further flight. Accomplishment of the initial Stage 2 inspection ends the repetitive Stage 1 inspections. Doing the modification required by paragraph (m) of this AD terminates the repetitive inspection requirements of this paragraph.

Exception to Corrective Action Instructions

(k) If any discrepancy, including but not limited to cracking, or broken, loose, or missing fasteners, is found during any inspection required by paragraphs (g) through (j) of this AD, and Boeing Alert Service Bulletin 747–53A2507, dated April 21, 2005, specifies to contact Boeing for appropriate action: Before further flight, repair the discrepancy using a method

approved in accordance with the procedures specified in paragraph (n) of this AD.

Reporting Requirement

(l) At the applicable time specified in paragraph (l)(1) or (l)(2) of this AD, submit a report of the findings (both positive and negative) of each Stage 1 inspection required by paragraph (g) of this AD to Boeing Commercial Airplanes; Attention: Manager, Airline Support; P.O. Box 3707 MC 04–ER; Seattle, Washington 98124–2207; fax (425) 266–5562. The report must include the inspection results, a description of any discrepancies found, the inspections performed, the airplane serial number, and the number of total accumulated flight cycles on the airplane. Under the provisions of the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*), the Office of Management and Budget (OMB) has approved the information collection requirements contained in this AD and has assigned OMB Control Number 2120–0056.

(1) For any inspection done after November 28, 2007: Submit the report within 30 days after the inspection.

(2) For any inspection done before November 28, 2007: Submit the report within 30 days after November 28, 2007.

New Requirements of This AD

Modification

(m) Except as provided by paragraphs (m)(1) and (m)(2) of this AD: At the times specified in paragraph 1.E, ''Compliance,'' of Boeing Alert Service Bulletin 747–53A2559, dated January 8, 2009, modify the frame-to-tension-tie joints at body stations 1120 through 1220; do all related investigative and applicable corrective actions; do the repetitive post-modification detailed inspections for cracking of the tension tie and frame structure and all applicable corrective actions; and do the additional modification. Do all actions in accordance with the Accomplishment Instructions of Boeing Alert Service Bulletin 747–53A2559, dated January 8, 2009. Modifying the frame-to-tension-tie joints at body stations 1120 through 1220 terminates the repetitive inspection requirements of paragraphs (g) and (j) of this AD.

(1) Where paragraph 1.E., ''Compliance,'' of Boeing Alert Service Bulletin 747–53A2559, dated January 8, 2009, specifies a compliance time relative to the original issue date of the service bulletin, this AD requires compliance within the specified compliance time after the effective date of this AD.

(2) Where Boeing Alert Service Bulletin 747–53A2559, dated January 8, 2009, specifies to contact Boeing for repair instructions or additional modification requirements: Before further flight, repair the discrepancy or do the modification using a method approved in accordance with the procedures specified in paragraph (n) of this AD.

Alternative Methods of Compliance (AMOCs)

(n)(1) The Manager, Seattle Aircraft Certification Office (ACO), FAA, has the authority to approve AMOCs for this AD, if requested using the procedures found in 14 CFR 39.19. Send information to ATTN: Ivan Li, Aerospace Engineer, Airframe Branch, ANM–120S, FAA, Seattle Aircraft Certification Office, 1601 Lind Avenue, SW., Renton, Washington 98057–3356; telephone (425) 917–6437; fax (425) 917–6590. Or, e-mail information to *9-ANM-Seattle-ACO-AMOC-Requests@faa.gov.*

(2) To request a different method of compliance or a different compliance time for this AD, follow the procedures in 14 CFR 39.19. Before using any approved AMOC on any airplane to which the AMOC applies, notify your principal maintenance inspector (PMI) or principal avionics inspector (PAI), as appropriate, or lacking a principal inspector, your local Flight Standards District Office. The AMOC approval letter must specifically reference this AD.

(3) An AMOC that provides an acceptable level of safety may be used for any repair required by this AD, if it is approved by an Authorized Representative for the Boeing Commercial Airplanes Delegation Option Authorization Organization who has been authorized by the Manager, Seattle ACO, to make those findings. For a repair method to be approved, the repair must meet the certification basis of the airplane and 14 CFR 25.571, Amendment 45, and the approval must specifically refer to this AD.

(4) AMOCs approved previously in accordance with AD 2007–23–18 are approved as AMOCs for the corresponding requirements of paragraphs (g) and (j) of this AD.

Issued in Renton, Washington, on June 24, 2009.

Ali Bahrami,

Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. E9–16463 Filed 7–10–09; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Docket No. FAA–2009–0552; Airspace Docket No. 09–ANM–7]

Proposed Establishment of Class E Airspace; Ronan, MT

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking.

SUMMARY: This action proposes to establish Class E airspace at Ronan, MT. Additional controlled airspace is necessary to accommodate aircraft using a new Area Navigation (RNAV) Global Positioning System (GPS) Standard Instrument Approach Procedure (SIAP) at Ronan Airport, Ronan, MT. The FAA is proposing this action to enhance the safety and management of aircraft operations at Ronan Airport.

DATES: Comments must be received on or before August 27, 2009.

ADDRESSES: Send comments on this proposal to the U.S. Department of Transportation, Docket Operations, M–30, West Building Ground Floor, Room W12–140, 1200 New Jersey Avenue, SE., Washington, DC 20590. Telephone (202) 366–9826. You must identify FAA Docket No. FAA–2009–0552; Airspace Docket No. 09–ANM–7, at the beginning of your comments. You may also submit comments through the Internet at *http://www.regulations.gov*.

FOR FURTHER INFORMATION CONTACT: Eldon Taylor, Federal Aviation Administration, Operations Support Group, Western Service Center, 1601 Lind Avenue, SW., Renton, WA 98057; telephone (425) 203–4537.

SUPPLEMENTARY INFORMATION:

Comments Invited

Interested parties are invited to participate in this proposed rulemaking by submitting such written data, views, or arguments, as they may desire. Comments that provide the factual basis supporting the views and suggestions presented are particularly helpful in developing reasoned regulatory decisions on the proposal. Comments are specifically invited on the overall regulatory, aeronautical, economic, environmental, and energy-related aspects of the proposal.

Communications should identify both docket numbers (FAA Docket No. FAA 2009–0552 and Airspace Docket No. 09–ANM–7) and be submitted in triplicate to the Docket Management System (see **ADDRESSES** section for address and phone number). You may also submit comments through the Internet at *http://www.regulations.gov*.

Commenters wishing the FAA to acknowledge receipt of their comments on this action must submit with those comments a self-addressed stamped postcard on which the following statement is made: ''Comments to FAA Docket No. FAA–2009–0552 and Airspace Docket No. 09–ANM–7.'' The postcard will be date/time stamped and returned to the commenter.

All communications received on or before the specified closing date for comments will be considered before taking action on the proposed rule. The proposal contained in this action may be changed in light of comments received. All comments submitted will be available for examination in the public docket both before and after the closing date for comments. A report summarizing each substantive public contact with FAA personnel concerned with this rulemaking will be filed in the docket.

Availability of NPRMs

An electronic copy of this document may be downloaded through the Internet at *http://www.regulations.gov*. Recently published rulemaking documents can also be accessed through the FAA's Web page at *http://www.faa.gov/airports_airtraffic/air_traffic/publications/airspace_amendments/*.

You may review the public docket containing the proposal, any comments received, and any final disposition in person in the Dockets Office (see the **ADDRESSES** section for the address and phone number) between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. An informal docket may also be examined during normal business hours at the Northwest Mountain Regional Office of the Federal Aviation Administration, Air Traffic Organization, Western Service Area, Operations Support Group, 1601 Lind Avenue, SW., Renton, WA 98057.

Persons interested in being placed on a mailing list for future NPRMs should contact the FAA's Office of Rulemaking, (202) 267–9677, for a copy of Advisory Circular No. 11–2A, Notice of Proposed Rulemaking Distribution System, which describes the application procedure.

The Proposal

The FAA is proposing an amendment to Title 14 Code of Federal Regulations (14 CFR) part 71 by establishing Class E airspace at Ronan, MT. Controlled airspace extending upward from 700 feet above the surface is necessary to accommodate aircraft using the new RNAV (GPS) SIAP at Ronan Airport, Ronan, MT. This action would enhance the safety and management of aircraft operations at the airport.

Class E airspace designations are published in paragraph 6005 of FAA Order 7400.9S, signed October 3, 2008, and effective October 31, 2008, which is incorporated by reference in 14 CFR 71.1. The Class E airspace designation listed in this document will be published subsequently in this Order.

The FAA has determined that this proposed regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. Therefore, this proposed regulation: (1) Is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a regulatory evaluation as the anticipated impact is so minimal. Since this is a routine matter that will only affect air traffic procedures and air navigation, it is certified that this proposed rule, when promulgated, would not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

The FAA's authority to issue rules regarding aviation safety is found in Title 49 of the U.S. Code. Subtitle 1, Section 106, describes the authority for the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the agency's authority. This rulemaking is promulgated under the authority described in Subtitle VII, Part A, Subpart I, Section 40103. Under that section, the FAA is charged with prescribing regulations to assign the use of the airspace necessary to ensure the safety of aircraft and the efficient use of airspace. This regulation is within the scope of that authority as it establishes controlled airspace at Ronan, MT.

List of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (air).

The Proposed Amendment

Accordingly, pursuant to the authority delegated to me, the Federal Aviation Administration proposes to amend 14 CFR part 71 as follows:

PART 71—DESIGNATION OF CLASS A, B, C, D, AND E AIRSPACE AREAS; AIR TRAFFIC SERVICE ROUTES; AND REPORTING POINTS

1. The authority citation for 14 CFR part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

2. The incorporation by reference in 14 CFR 71.1 of the FAA Order 7400.9S, Airspace Designations and Reporting Points, signed October 3, 2008, and effective October 31, 2008, is amended as follows:

Paragraph 6005. Class E airspace areas extending upward from 700 feet or more above the surface of the earth.

* * * * *

ANM MT E5 Ronan, MT [New]

Ronan Airport, MT

(Lat. 47°34′02″ N., long. 114°06′04″ W.)

That airspace extending upward from 700 feet above the surface within an 8.4-mile radius of Ronan Airport, excluding that airspace within Federal airways.

* * * * *

Issued in Seattle, Washington, on June 30, 2009.

H. Steve Karnes,

Acting Manager, Operations Support Group, Western Service Center.

[FR Doc. E9–16501 Filed 7–10–09; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 73

[Docket No. FAA–2009–0490; Airspace Docket No. 09–AWP–3]

RIN 2120–AA66

Proposed Establishment of Restricted Area R–2502A; Fort Irwin, CA

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking.

SUMMARY: This action proposes to establish a restricted area (R–2502A) at Fort Irwin, CA, as part of a Department of the Army initiative at the National Training Center (NTC). The NTC is being expanded to meet the critical need of the Army for additional training land and airspace suitable for maneuvering large numbers of military personnel and equipment. Additionally, this action would modify the Silver military operation area (MOA) in the vicinity of the NTC Complex. Unlike restricted areas, which are designated under 14 CFR part 73, MOAs are not rulemaking airspace actions. However, since the proposed R–2502A infringes on the Silver MOA, the FAA is including a description of the Silver MOA change in this rule. The MOA change described here will also be published in the National Flight Data Digest (NFDD). The Army requested these airspace changes to provide the additional special use airspace (SUA) above the expanded ground maneuver area to facilitate realistic combat training at the NTC.

DATES: Comments must be received on or before August 27, 2009.

ADDRESSES: Send comments on the proposal to the U.S. Department of Transportation, Dockets Operations, M–30, 1200 New Jersey Avenue, SE., West Building Ground Floor, Room W12–140, Washington, DC 20590–0001; telephone: (202) 366–9826. You must identify docket No. FAA–2009–0490 and Airspace Docket No. 09–AWP–3, at the beginning of your comments. You may also submit comments on the Internet at *http://www.regulations.gov.*

FOR FURTHER INFORMATION CONTACT: Ken McElroy, Airspace and Rules Group,

Office of System Operations Airspace and AIM, Federal Aviation Administration, 800 Independence Avenue, SW., Washington, DC 20591; telephone: (202) 267–8783.

SUPPLEMENTARY INFORMATION:

Comments Invited

Interested parties are invited to participate in this proposed rulemaking by submitting such written data, views, or arguments as they may desire. Comments that provide the factual basis supporting the views and suggestions presented are particularly helpful in developing reasoned regulatory decisions on the proposal. Comments are specifically invited on the overall regulatory, aeronautical, economic, environmental, and energy-related aspects of the proposal.

Communications should identify both docket numbers (FAA Docket No. FAA–2009–0490 and Airspace Docket No. 09–AWP–3) and be submitted in triplicate to the Federal Docket Management System (see **ADDRESSES** section for address and phone number). You may also submit comments through the Internet at *http://www.regulations.gov.*

Commenters wishing the FAA to acknowledge receipt of their comments on this action must submit with those comments a self-addressed, stamped postcard on which the following statement is made: ''Comments to FAA Docket No. FAA–2009–0490 and Airspace Docket No. 09–AWP–3.'' The postcard will be date/time stamped and returned to the commenter.

All communications received on or before the specified closing date for comments will be considered before taking action on the proposed rule. The proposal contained in this action may be changed in light of comments received. All comments submitted will be available for examination in the public docket both before and after the closing date for comments. A report summarizing each substantive public contact with FAA personnel concerned with this rulemaking will be filed in the docket.

Availability of NPRMs

An electronic copy of this document may be downloaded through the Internet at *http://www.regulations.gov.* Recently published rulemaking documents can also be accessed through the FAA's Web page at *http://www.faa.gov/airports_airtraffic/air_traffic/publications/airspace_amendments/.*

You may review the public docket containing the proposal, any comments received, and any final disposition in person in the Dockets Office (see **ADDRESSES** section for address and phone number) between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. An informal docket may also be examined during normal business hours at the office of the Western Service Center, Operations Support Group, Federal Aviation Administration, 1601 Lind Avenue, SW., Renton, WA 98055.

Persons interested in being placed on a mailing list for future NPRMs should contact the FAA's Office of Rulemaking, (202) 267–9677, for a copy of Advisory Circular No. 11–2A, Notice of Proposed Rulemaking Distribution System, which describes the application procedure.

Background

The NTC at Fort Irwin, California, is the only instrumented training area in the world suitable for force-on-force and live fire training of heavy brigade-sized military forces. It provides the Army with essential training opportunities necessary to maintain and improve military readiness and promote national security.

The Congress in 2001, directed the Department of the Army and the Department of the Interior to draft a proposed plan that would expand the maneuver training lands at the NTC.

This airspace proposal aligns with that land expansion in order to provide overlying airspace to conduct realistic combat training. The expanded airspace enhances the training value of the land based on training goals, equipment capabilities, and Army requirements. Additionally, the employment of aviation assets, explosives, flares, smoke, and other pyrotechnics devices will be deployed in the new airspace.

The FAA supports this proposal. However, the FAA would have concerns for any additional expansion of the airspace in this area higher than 16,000 feet mean sea level (MSL) in the proposed R–2502A due to impacts to the National Airspace System (NAS). A review by the FAA Los Angeles Air Route Traffic Control Center personnel made the following observations: (1) The airspace adjacent to the south of proposed R–2502A is used for separation and sequencing of arriving and departing aircraft for the Los Angeles basin. Air traffic in this area regularly operates at system capacity. A reduction of usable airspace would significantly affect air traffic control services and cause delays to system users. (2) The airspace along the northeast boundary of proposed R–2502A is used for the separation and sequencing of air traffic into Las Vegas, McCarran Airport. A reduction of usable airspace would significantly affect air traffic control services and cause delays to system users. (3) Because of R–2501, the usable airspace along the southern and eastern boundaries of R–2502 East is very constrained. This narrow corridor is heavily used for arrivals and departures at the Los Angeles, Burbank, Van Nuys, and Las Vegas airports. Keeping aircraft from deviating into the proposed R–2502A vertical addition during the months when extensive convective weather is common would be difficult.

Military Operation Area (MOA)

Restricted areas are regulatory airspace designations, under Title 14 Code of Federal Regulations (CFR) part 73, which are established to confine or segregate activities considered hazardous to non-participating aircraft. A MOA is a non-rulemaking type of SUA established to separate or segregate certain non-hazardous military flight activities from aircraft operating in accordance with instrument flight rules (IFR), and to identify for visual flight rules (VFR) pilots where those activities are conducted. IFR aircraft may be routed through an active MOA only when air traffic control can provide approved separation from the MOA activity. VFR pilots are not restricted from flying in an active MOA, but are advised to exercise caution while doing so.

Unlike restricted areas, which are designated through rulemaking procedures, MOAs are non-rulemaking airspace areas that are established administratively and published in the National Flight Data Digest. Normally MOA proposals are not published in a NPRM, but instead, are advertised for public comment through a non-rule circular that is distributed by an FAA Service Center office to aviation interests in the affected area. However, when a non-rulemaking action is connected to a rulemaking action, FAA procedures allow for the non-rulemaking proposal to be included in the NPRM. In such cases, the NPRM replaces the non-rule circularization requirement. Because the change to the Silver MOA North is necessary, due to the proposed establishment of the restricted area, the MOA is being modified to exclude the airspace contained in the proposed R–2502A.

Proposed MOA Change

Silver MOA North, CA

Boundaries. Beginning at lat. 35°39′00″ N., long. 115°53′03″ W.; to lat. 35°24′30″ N., long. 115°53′03″ W.; to lat. 35°06′50″ N., long. 116°20′00″ W.; to lat. 35°04′30″ N., long. 116°29′00″ W.; to lat.

35°07′00″ N.; long. 116°34′03″ W.; to point of beginning. Excluding the airspace below 3,000 feet AGL within a 3NM radius of the town of Baker, CA (lat. 35°16′00″ N. long. 116°04′33″ W.;) and R2502A.

The Proposal

The FAA is proposing an amendment to Title 14 Code of Federal Regulations (14 CFR) part 73 to establish Restricted Areas R–2502A at Fort Irwin, CA. The U.S. Army has requested this restricted area because the existing special use airspace does not include the airspace above the expanded land maneuver area created to support the NTC. This proposed action is required to ensure a safe training environment, isolated from the public, for military air and ground maneuvers from the surface to the upper limits of restricted airspace.

The FAA has determined that this proposed regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. Therefore, this proposed regulation: (1) Is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under Department of Transportation (DOT) Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a regulatory evaluation as the anticipated impact is so minimal. Since this is a routine matter that will only affect air traffic procedures and air navigation, it is certified that this proposed rule, when promulgated, will not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

The FAA's authority to issue rules regarding aviation safety is found in Title 49 of the United States Code. Subtitle I, Section 106 describes the authority of the FAA Administrator. Subtitle VII, Aviation Programs, describes in more detail the scope of the agency's authority.

This rulemaking is promulgated under the authority described in Subtitle VII, Part A, Subpart I, Section 40103. Under that section, the FAA is charged with prescribing regulations to assign the use of the airspace necessary to ensure the safety of aircraft and the efficient use of airspace. This regulation is within the scope of that authority as it proposes to establish restricted area airspace at Fort Irwin, CA.

Environmental Review

This proposal will be subjected to the appropriate environmental analysis in accordance with FAA Order 1050.1E, Environmental Impacts: Policies and Procedures, prior to any FAA final regulatory action.

List of Subjects in 14 CFR Part 73

Airspace, Prohibited areas, Restricted areas.

The Proposed Amendment

In consideration of the foregoing, the Federal Aviation Administration proposes to amend 14 CFR part 73 as follows:

PART 73—SPECIAL USE AIRSPACE

1. The authority citation for part 73 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 73.25 [Amended]

2. § 73.25 is amended as follows:

* * * * *

R–2502A Fort Irwin, CA [New]

Boundaries. Beginning at lat. 35°25′48″ N., long. 116°18′48″ W.; to lat. 35°25′30″ N., long. 116°09′46″ W.; to lat. 35°23′15″ N., long. 116°09′47″ W.; to lat. 35°06′54″ N., long. 116°30′17″ W.; to lat. 35°07′00″ N., long. 116°34′03″ W.; to lat. 35°18′45″ N., long. 116°18′48″ W. to point of beginning.

Designated altitudes. Surface to 16,000 feet MSL.

Time of designation. Continuous.

Controlling agency. FAA, Hi-Desert TRACON, Edwards, CA.

Using agency. Commander, Fort Irwin, CA.

* * * * *

Issued in Washington, DC, on July 6, 2009.

Edith V. Parish,

Manager, Airspace and Rules Group.

[FR Doc. E9–16480 Filed 7–10–09; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF THE INTERIOR

National Park Service

36 CFR Part 7

RIN 1024–AD50

Special Regulations; Areas of the National Park System

AGENCY: National Park Service, Interior.

ACTION: Proposed Rule.

SUMMARY: The National Park Service is proposing this rule to update its regulations for managing use of the Colorado River and adjoining federally owned lands administered by the National Park Service within Grand Canyon National Park. Changes to the current rule are necessary to implement portions of the park's recently revised Colorado River Management Plan. Current regulations govern boat trips on the Colorado River within the park upstream from Diamond Creek (approximately River Mile 226). In accordance with the new Colorado River Management Plan, the proposed rule will apply to the entire Colorado River within the park, including the reach of the river downstream from Diamond Creek to the boundary between the park and Lake Mead National Recreation Area (approximately River Mile 277).

DATES: Comments must be received by September 11, 2009.

ADDRESSES: You may submit your comments, identified by Regulatory Information Number 1024–AD50 (RIN), by any of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Mail:* National Park Service, WASO, Mike Archer, Chief Ranger, Grand Canyon National Park, P.O. Box 129, Grand Canyon, Arizona.

All submissions received must include the agency name and RIN. For additional information see ''Public Participation'' under **SUPPLEMENTARY INFORMATION** below.

FOR FURTHER INFORMATION CONTACT: Palma Wilson, Deputy Superintendent—Operations, Grand Canyon National Park, P.O. Box 129, Grand Canyon, Arizona 86023, *Palma_Wilson@nps.gov*, (fax) (928) 638–7815.

SUPPLEMENTARY INFORMATION:

Description of the Park

Grand Canyon National Park, Arizona, contains and protects what many people consider to be the most scenic and scientifically significant arid-land canyon in the world. Congress established the park in the Act of February 26, 1919, and enlarged its boundaries in subsequent legislation enacted in 1926, 1928, and 1975. As described in the latest such enactment, the Grand Canyon National Park Enlargement Act, the park consists of approximately one million, two hundred thousand acres of lands, waters, and interests therein, all as depicted on a boundary map referenced in the legislation.

The reach of the Colorado River in the park provides a unique combination of thrilling whitewater adventure and magnificent vistas of a remarkable geologic landscape, including remote and intimate side canyons. The 277-mile-long river corridor is home to

unique and abundant natural and cultural resources, including diverse wildlife, threatened and endangered species, archeological sites, caves, and natural soundscapes. For these reasons, a river trip through the Grand Canyon is one of the most sought-after backcountry experiences in the country, and nearly 30,000 visitors per year run the river. In addition, more than 50,000 visitors per year take flat-water excursions lasting several hours in the lower gorge on pontoon boats operated by or for the Hualapai Tribe.

Purposes of the Park

In the Act of February 26, 1919, Congress dedicated and set apart certain described lands under the name of the Grand Canyon National Park ''as a public park for the benefit and enjoyment of the people.'' In the Grand Canyon National Park Enlargement Act, Congress recognized ''that the entire Grand Canyon, from the mouth of the Paria River to the Grand Wash Cliffs, including tributary side canyons and surrounding plateaus, is a natural feature of national and international significance.'' In that act Congress also recognized the need for ''further protection and interpretation of the Grand Canyon in accordance with its true significance.''

The park's General Management Plan, finalized in 1995, states that as a place of national and global importance Grand Canyon National Park is to be managed to ''preserve and protect its natural and cultural resources and ecological processes, as well as its scenic, aesthetic, and scientific values'' and to ''provide opportunities for visitors to experience and understand the environmental interrelationships, resources, and values of Grand Canyon without impairing the resource.''

The park's Colorado River Management Plan was revised (Record of Decision published in the **Federal Register** on March 23, 2006) to address both long-standing and recent issues concerning resource protection, visitor experience, and public services along the Colorado River corridor; to consider the impact of National Park Service river management on federally recognized American Indian tribes whose reservations adjoin Grand Canyon National Park; and to fulfill the requirements of a 2002 agreement that settled litigation over the previous river management plan.

Resource Issues

Nearly 30,000 visitors per year participate in commercial or noncommercial river trips on the Colorado River within Grand Canyon National Park. In addition, more than 50,000 visitors per year take flat-water excursions lasting several hours in the lower gorge on pontoon boats operated by or for the Hualapai Tribe. Recreational activities along the river corridor in the park may impact the park's natural and cultural resources (including resources possessing wilderness values), the experiences of park visitors, park operations, and adjoining lands owned or administered by other federal agencies or neighboring American Indian tribes. Those impacts are analyzed in depth in Chapter 4 of the Final Environmental Impact Statement for the recently revised Colorado River Management Plan.

As currently written, 36 CFR 7.4(b) governs the use of the Colorado River within the park upstream from Diamond Creek (approximately River Mile 226). This proposed rule would apply to the entire Colorado River and adjoining federally owned lands within the park, including the reach of the river downstream from Diamond Creek (River Mile 226) to the boundary between the park and Lake Mead National Recreation Area (approximately River Mile 277). This proposed rule (1) would clarify that commercial river trips below Diamond Creek, including those operated by or for the Hualapai Tribe, must obtain National Park Service approval in the form of a permit, contract, or other written agreement, as required by 36 CFR 5.3 and other applicable laws, and (2) would require that noncommercial river trips using any part of the Colorado River within Grand Canyon National Park, including the river downstream from Diamond Creek, obtain a permit issued by the Superintendent. The proposed rule also would update visitor-use restrictions and camping closures and delete unnecessary provisions in the current regulation.

The Colorado River Management Plan planning process involved extensive public scoping beginning in 1997 and included numerous public meetings and stakeholder workshops; opportunity for the public to comment in person or via email or regular mail; and consultation with other agencies and culturally affiliated American Indian tribes. During the planning process, approximately 2,000 people attended public meetings, and the National Park Service received approximately 24,000 written responses from the public containing over 90,000 individual comments. For additional information see the *Purpose of and Need for the Action, Background Information* and *Appendix B: Public Scoping Summary* sections of the Final Environmental Impact Statement, which detail the public scoping process and the issues and concerns raised in scoping; Volume II, Chapter 5 of the Final Environmental Impact Statement, which includes a list of organizations and agencies consulted during the planning process; and Volume III of the Final Environmental Impact Statement, which includes responses to all substantive comments received during the process. The Final Environmental Impact Statement can be found on the park's Web site at *http://www.nps.gov/archive/grca/crmp/* or at Grand Canyon National Park, 823 N. San Francisco, Ste A, Flagstaff, AZ 86001.

The National Park Service's management of the Colorado River within Grand Canyon National Park may affect resources of the Navajo Nation, the Havasupai Tribe, or the Hualapai Tribe, each of which shares a boundary with the park. Furthermore, the National Park Service's management of the Colorado River within the park will affect businesses operating on the river under agreements with the Hualapai Tribe. Potential impacts for culturally affiliated American Indian tribes were addressed in the park's recently revised Colorado River Management Plan.

At its request, the Hualapai Tribe served as a cooperating agency in the preparation of the Environmental Impact Statement for the new Colorado River Management Plan. The final plan represents agreement between the National Park Service and the Tribe on most issues relating to river use in the park. However, the Tribe's preferred alternative for the lower gorge envisioned even greater pontoon boat use than the increase authorized by the final plan. The National Park Service intends to offer the Tribe a non-competitive concession contract for its lower gorge operations in accordance with the final plan and with the National Park Service Concessions Management Improvement Act of 1998 and implementing regulations found in 36 CFR Part 51.

For more information on consultation and coordination with American Indian tribes see Chapter 5 of the Final Environmental Impact Statement for the Colorado River Management Plan. The Final Environmental Impact Statement can be found on the park's Web site at *http://www.nps.gov/archive/grca/crmp/* or at Grand Canyon National Park, 823 N. San Francisco, Ste A, Flagstaff, AZ 86001.

The Draft and Final Environmental Impact Statements

This rule would implement portions of Grand Canyon National Park's recently revised Colorado River Management Plan. The National Park Service prepared a Draft Environmental Impact Statement and a Final Environmental Impact Statement. A Record of Decision was published in the **Federal Register** on March 23, 2006. The planning process began in 1997 with public scoping and stakeholder workshops. During the process, approximately 2,000 people attended a total of 14 public meetings and the NPS received approximately 24,000 written responses from the public containing over 90,000 individual comments. Impacts associated with this rule are analyzed in the Final Environmental Impact Statement for the Colorado River Management Plan. The Record of Decision and the Final Environmental Impact Statement are available on the park's Web site at *http://www.nps.gov/archive/grca/crmp/* or at Grand Canyon National Park, 823 N. San Francisco, Ste A, Flagstaff, AZ 86001.

Section-by-Section Analysis

Section 7.4(b) Colorado River Boat Trips

Section 7.4(b), *''Colorado River boat trips''* would amend the existing regulation, which applies to boat trips on the Colorado River only between Lee's Ferry (River Mile 0) and Diamond Creek (approximately River Mile 226). The amended section would apply to all boat trips on the entire length of the Colorado River in Grand Canyon National Park.

Section 7.4(b)(1) would clarify that all commercial boat trips on the Colorado River in Grand Canyon National Park must be authorized by the National Park Service through a permit, contract, or other written agreement, as required by 36 CFR 5.3 and other applicable laws.

Section 7.4(b)(2) would require all noncommercial river trips on the entire length of the Colorado River in Grand Canyon National Park to be authorized under a permit issued by the Superintendent. Currently section 7.4 only requires permits for noncommercial river trips from Lee's Ferry (River Mile 0) to Diamond Creek (approximately River Mile 226). This section would extend the permit requirement to the entire river within the park.

Section 7.4(b)(3) would renumber and clarify the definition of ''commercial'' river trips and ''noncommercial'' river trips. This section is currently found at 7.4(b)(3)(iii).

Section 7.4(b)(4) would create a new standalone section with language that is currently found in section 7.4(b)(3) and that authorizes the Superintendent to limit the number of permits, contracts and other written agreements, or amend the terms and conditions of those permits, contracts and other written agreements, to ensure public safety or to protect park resources.

Section 7.4(b)(5)(i),(ii),(iii), and (iv) would set out operational conditions required for all river trips. These conditions are not new except that they would apply to the entire length of the Colorado River within the park. These four conditions are currently found in sections 7.4(b)(1) and (2).

Section 7.4(b)(6) would renumber the section that requires human waste to be removed from the park in a manner prescribed by the Superintendent. This section is currently found at 7.4(b)(4).

Section 7.4(b)(7) would renumber and update the section that contains requirements for camp fires currently found at 7.4(b)(4). This section would continue to require that fires be kindled only on beaches and that fires be completely extinguished with water. It would add the requirements that fires must be kindled in elevated metal pans and that ash and charcoal must be removed from the park. These restrictions are currently included in permit conditions for both commercial and noncommercial river trips.

Section 7.4(b)(8)(i) through (vii) would list camping closures that are currently found at 7.4(b)(9) and would add camping closures in the following areas: the Phantom Ranch area, on the banks of the Colorado River between the Black Bridge and 0.25 miles below the mouth of Pipe Creek; the Elves Chasm drainage from Royal Arch to the Colorado River; and the Deer Creek drainage from Deer Creek Falls to the Colorado River. Section 7.4(b)(8)(vi) would clarify that the camping closure at the mouth of Havasu Creek includes the Havasu Creek drainage from the boundary between the park and the Havasupai Indian reservation to the Colorado River. These areas are heavily visited by river trips and the closures would protect resources in the areas by limiting river trip participants to day-use only.

The revision of section 7.4(b) would remove sections 7.4(b)(5), (b)(7), and (b)(8). Current section 7.4(b)(5) prohibits pets on river trips. Pets are prohibited in all areas below the rim of the Grand Canyon, including the Colorado River corridor, by the Superintendent under the authority granted in 36 CFR 2.15(a)(1), making the current section 7.4(b)(5) unnecessary.

Current section 7.4(b)(7) allows picnicking on beach areas along the Colorado River. This use is currently authorized by 36 CFR 2.11, making the current section 7.4(b)(7) unnecessary.

Current section 7.4(b)(8) allows swimming and bathing in the waters of the Colorado River except in locations immediately above rapids, eddies and riffles or near rough water. Removing this section would allow swimming and bathing in all areas of the Colorado River, as authorized by 36 CFR 3.16. The National Park Service expects swimmers and bathers to take responsibility for their own safety and exercise good judgment while using the waters of the Colorado River.

Compliance With Other Laws

Regulatory Planning and Review (Executive Order 12866)

This document is a significant rule and has been reviewed by the Office of Management and Budget under Executive Order 12866. We have made the assessments required by E.O. 12866 and the results are available by writing to the address in the addresses section or as supporting material to this rulemaking found at *http://www.regulations.gov*.

(1) This rule would not have an effect of $100 million or more on the economy. It would not adversely affect in a material way the economy, productivity, competition, jobs, the environment, public health or safety, or local, governments or communities. However, it may affect the Hualapai Tribal economy in the future by capping the number of people who may take flat water excursions in the lower gorge operated by or for the Hualapai Tribe.

(2) This rule would not create a serious inconsistency or otherwise interfere with an action taken or planned by another agency.

(3) This rule does not alter the budgetary effects of entitlements, grants, user fees, or loan programs or the rights or obligations of their recipients.

(4) OMB has determined that this rule raises novel legal or policy issues.

Regulatory Flexibility Act

The Department of the Interior certifies that this document would not have a significant economic effect on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601–12 (2000)).

A qualitative regulatory flexibility analysis was published on January 11, 2008, using data from a cost-benefit analysis prepared for the river management plan. The analysis showed a net benefit of $2.9 million to the

regional economy and an increase of 47 jobs for the area above Diamond Creek. For the area on the Colorado River below Diamond Creek the result was a predicted major beneficial economic impact on Hualapai tribal revenue, and a negligible impact on the regional economy.

Small Business Regulatory Enforcement Fairness Act

This rule is not a major rule under 5 U.S.C. subsection 804(2) of the Small Business Regulatory Enforcement Fairness Act. This rule:

a. Does not have an annual effect on the economy of $100 million or more.

b. Will not cause a major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions.

c. Does not have significant adverse effects on competition, employment, investment, productivity, innovation, or the ability of United States-based enterprises to compete with foreign-based enterprises.

Unfunded Mandates Reform Act

This rule does not impose an unfunded mandate on State, local, or tribal governments or the private sector of more than $100 million per year. Except as described elsewhere with respect to the Hualapai Tribe, the rule does not have a significant or unique effect on State, local or tribal governments or the private sector.

Takings (Executive Order 12630)

In accordance with Executive Order 12630, this rule does not have significant takings implications.

Federalism (Executive Order 13132)

In accordance with Executive Order 13132, this rule does not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

Civil Justice Reform (Executive Order 12988)

This rule meets the applicable standards set forth in sections 3(a) and 3(b)(2) of the executive order.

Paperwork Reduction Act

This regulation does not require information collection from 10 or more parties and a submission under the Paperwork Reduction Act is not required. An OMB form 83–I is not required.

National Environmental Policy Act

This rule would implement portions of the recently revised Colorado River Management Plan. All impacts associated with this rule are fully analyzed in the Final Environmental Impact Statement for the Colorado River Management Plan. The Final Environmental Impact Statement is available on the park's Web site at *http://www.nps.gov/archive/grca/crmp/* or at Grand Canyon National Park, 823 N. San Francisco, Ste A, Flagstaff, AZ 86001.

Government-to-Government Relationship With Tribes

The National Park Service's management of the Colorado River within Grand Canyon National Park may affect the resources of the Navajo Nation, the Havasupai Tribe, and the Hualapai Tribe, each of which shares a boundary with the park, and historic properties in the park to which those and other tribes might attach religious and cultural significance. Therefore, in accordance with the provisions of the National Environmental Policy Act; the National Historic Preservation Act; the April 29, 1994, Presidential Memorandum on Government-to-Government Relations with Native American Tribal Governments; Executive Order 13007, 3 CFR 196 (1997); Executive Order 13175, 3 CFR part 304 (2001); 512 Department of Interior Manual 2; National Park Service Management Policies 2001 and 2006; and National Park Service Director's Order #71: Relationship with Indian Tribes, the National Park Service established regular consultation with culturally affiliated, federally recognized American Indian tribes during the revision of the Colorado River Management Plan to try to understand and address tribal issues and concerns. For a list of American Indian tribes consulted and a description of the process and issues identified during the process, see Chapter 5 of the Final Environmental Impact Statement for the Colorado River Management Plan. The Final Environmental Impact Statement can be found on the park's Web site at *http://www.nps.gov/archive/grca/crmp/* or at Grand Canyon National Park, 823 N. San Francisco, Ste A, Flagstaff, AZ 86001.

Clarity of Rule

Executive Order 12866 requires each agency to write regulations that are easy to understand. We invite your comments on how to make this rule easier to understand, including answers to questions such as the following: (1) Are the requirements in the rule clearly stated? (2) Does the rule contain technical language or jargon that interferes with its clarity? (3) Does the format of the rule (grouping and order of sections, use of headings, paragraphing, etc.) aid or reduce its clarity? (4) Would the rule be easier to read if it were divided into more (but shorter) sections? (A ''section'' appears in bold type and is preceded by the symbol ''§'' and a numbered heading; for example § 7.XX * * *) (5) Is the description of the rule in the **SUPPLEMENTARY INFORMATION** section of the preamble helpful in understanding the proposed rule? What else could we do to make the rule easier to understand?

Send a copy of any comments that concern how we could make this rule easier to understand to: Office of Regulatory Affairs, Department of the Interior, Room 7229, 1849 C Street, NW., Washington, DC 20240. You may also email the comments to this address: *Exsec@ios.doi.gov*.

Drafting Information: The principal contributors to this proposed rule are: Chris Pergiel, Alaska Regional Chief Ranger; Robin Martin, Program Analyst, Grand Canyon National Park; and Jerry Case, Superintendent, Bighorn Canyon National Recreation Area.

Public Availability of Comments

Before including your address, phone number, e-mail address, or other personal identifying information in your comment, you should be aware that your entire comment—including your personal identifying information—may be made publicly available at any time. While you can ask us in your comment to withhold your personal identifying information from public review, we cannot guarantee that we will be able to do so.

List of Subjects in 36 CFR Part 7

National Parks, Reporting and recordkeeping requirements.

In consideration of the foregoing, the National Park Service proposes to amend 36 CFR part 7 as follows:

PART 7—SPECIAL REGULATIONS, AREAS OF THE NATIONAL PARK SYSTEM

1. The authority for part 7 continues to read as follows:

Authority: 16 U.S.C. 1, 3, 9a, 460(q), 462(k); Sec. 7.96 also issued under DC Code 8–137(1981) and DC Code 40–721 (1981).

2. In § 7.4, paragraph (b) is revised as follows:

§ 7.4 Grand Canyon National Park.

* * * * *

(b) *Colorado River boat trips.* The following applies to all persons using the waters of the Colorado River, or

federally owned lands administered by the National Park Service along the river, within Grand Canyon National Park:

(1) Commercial use of the Colorado River within Grand Canyon National Park must be authorized by the National Park Service through a permit, contract, or other written agreement. Each commercial river trip must designate a trip leader who is responsible for ensuring that all trip participants comply with the terms and conditions of the authorizing instrument.

(2) Noncommercial use of the Colorado River within Grand Canyon National Park, including research by any agency, entity, or person except the National Park Service, must be authorized by a permit issued by the Superintendent. The permit holder is deemed to be the trip leader and is responsible for ensuring that all trip participants comply with the terms and conditions of the permit.

(3) A river trip is commercial if any participant receives money or other compensation for organizing, outfitting, or guiding the trip. A river trip is noncommercial if:

(i) There is a bona fide sharing of expenses among trip participants; and

(ii) No participant receives any money or other compensation for organizing, outfitting, or guiding the trip.

(4) At any time the Superintendent may limit the number of permits, contracts, and other written agreements issued or may amend the terms and conditions of those permits, contracts, and other written agreements to ensure public safety or to protect park resources.

(5) From Lees Ferry (River Mile 0) to Separation Canyon (approximately River Mile 239.5):

(i) No one may operate a vessel engaging in predominately upstream travel;

(ii) No one may operate a vessel powered by a motor or motors whose total horsepower exceeds 55;

(iii) Every person aboard a vessel must wear a personal floatation device approved by the United States Coast Guard for the specific activity in which the person is engaged; and

(iv) One additional personal floatation device must be carried on each vessel for every ten persons on board.

(6) All solid human waste must be removed from the park and disposed of in the manner prescribed by the Superintendent.

(7) Fire may be kindled only on beaches in an elevated metal fire pan that contains the fire. All fires must be completely extinguished with water before the river trip participants leave the area. All ash and charcoal must be removed from the park.

(8) The following areas are closed to camping:

(i) The banks of the Colorado River from the mouth of the Paria River to Navajo Bridge;

(ii) Red Wall Cavern;

(iii) The banks of the Colorado River from the Black Bridge to 0.25 miles below the mouth of Pipe Creek;

(iv) The Elves Chasm drainage from Royal Arch to the Colorado River;

(v) The Deer Creek drainage from Deer Creek Falls to the Colorado River;

(vi) The Havasu Creek drainage from the boundary between the park and the Havasupai Indian reservation to the Colorado River; and

(vii) Any other areas closed to camping by the Superintendent.

(9) The Superintendent may temporarily limit, restrict, or terminate access to or use of areas after taking into consideration public health and safety, natural and cultural resource protection, and other management activities and objectives.

* * * * *

Will Shafroth,

Acting Assistant Secretary, Fish and Wildlife and Parks.

[FR Doc. E9–16482 Filed 7–10–09; 8:45 am]

BILLING CODE 4312–ED–P

POSTAL REGULATORY COMMISSION

39 CFR Parts 3001 and 3004

[Docket No. RM2009–6; Order No. 230]

Freedom of Information Act Regulations

AGENCY: Postal Regulatory Commission.

ACTION: Proposed rulemaking.

SUMMARY: The Commission is proposing to revise rules related to the Freedom of Information Act. The proposed revisions implement recent amendments, clarify the relationship of these rules to others, and make minor editorial and conforming changes.

DATES: Initial comments due: August 12, 2009; reply comments due August 27, 2009.

ADDRESSES: Submit comment electronically via the Commission's Filing Online system at *http://www.prc.gov*.

FOR FURTHER INFORMATION CONTACT: Stephen L. Sharfman, General Counsel, 202–789–6820.

SUPPLEMENTARY INFORMATION:

I. Introduction

The Postal Regulatory Commission (Commission) proposes to update its rules governing Freedom of Information Act (FOIA), 5 U.S.C. 552, requests. The Openness Promotes Effectiveness in our National Government Act of 2007, Public Law 110–175, 121 Stat. 2524 (OPEN Government Act) was signed into law on December 31, 2007 and amends 5 U.S.C. 552. The amendments require an update to the Commission's FOIA rules published in 39 CFR part 3004.

On January 21, 2009, President Obama issued a memorandum for the heads of all Federal agencies and departments directing a presumption of disclosure for all decisions involving FOIA.[1] At the direction of the President, the Attorney General issued a memorandum for the heads of all Federal agencies and departments which instructs agencies to use ''a presumption of openness'' and take proactive steps to publicly post information online in advance of any request.[2]

As a result of amendments to 5 U.S.C. 552, policy memoranda from the President and Attorney General, and changes to the regulatory framework and organization under the Postal Accountability and Enhancement Act (PAEA), Public Law 109–435, 120 Stat. 3198 (2006), the Commission proposes to amend its FOIA rules in 39 CFR part 3004.

II. Discussion of the Proposed Rules

The Commission proposes to implement the OPEN Government Act with modifications to its FOIA rules in 39 CFR part 3004. First, the Commission adds proposed rule 3004.42, which provides each person making a FOIA request with a unique tracking number, and a mechanism to track the status of a FOIA request. Second, the Commission adds a paragraph to the section governing fees charged for requests. Proposed rule 3004.52(e) is added to reflect a change in the statute that does not allow an agency to collect fees if it fails to meet applicable time limits imposed by the statute. Third, the Commission adds proposed rule 3004.60, which designates the Director

[1] Memorandum for the Heads of Executive Departments and Agencies, January 21, 2009 (74 FR 4683 (January 26, 2009)).

[2] Office of the Attorney General, Memorandum for Heads of Executive Departments and Agencies, March 19, 2009.

of the Office of Public Affairs and Government Relations as the FOIA Public Liaison.

To align the Commission's FOIA policies with the President's vision for a more open and accountable government, the Commission makes several changes to part 3004. First, the Commission adds proposed rule 3004.2, announcing the ''presumption of openness'' to be applied to any requests under FOIA, and stating that it proactively posts public records on its Web site in advance of any public request. Second, the Commission adds proposed rule 3004.43(c), which allows for a partial grant of a request, rather than a denial, when the Commission cannot make a full disclosure. Third, the Commission edits the language in proposed rule 3004.43 and requires, when a request is denied in whole or in part, an explanation of the basis for withholding the records and a description of the foreseeable harm.

To make the information pertaining to FOIA contained in part 3004 easier to find, the proposed amendment divides the regulations into several smaller individual regulations. For example, proposed rule 3004.6 Fees is separated into five regulations. Paragraph (a) of section 3004.6 becomes proposed rule 3004.50 Fees—definitions as used in this subpart. The information in paragraph (b) is relocated to proposed rule 3004.52 Fees—general provisions, and the information in paragraph (c)(1) is moved to proposed rule 3004.51 Fees—category of requests. Paragraph (c)(2) becomes proposed rule 3004.53 Fee schedule. Miscellaneous information currently in sections 3004.6(b), (c)(2)(i) and (f) is consolidated in proposed rule 3004.52 Fees—general provisions. Finally, paragraphs (d) and (e) are relocated to proposed rule 3004.54 Procedure for assessing and collecting fees. The substance of the regulations being divided is not modified, although the existing text is simplified. Similar minor editing is employed throughout the proposed rules and noted in the section-by-section analysis.

Finally, the Commission references its rules governing the treatment of non-public materials in several sections.[3] Proposed rule 3004.10 references section 3007.10 as an exception to ''public records'' as section 3007.10 allows persons to designate materials as non-public and initially exempt from disclosure. Similarly, proposed rule 3004.30(d) is added which formalizes that FOIA requests for Postal Service records will be referred to the Postal Service. The paragraph also indicates that records may be requested through the Commission's rules in part 3007. Finally, proposed rule 3004.70, which governs submission of business information, references part 3007 and the submitter's ability to file an application for non-public treatment pursuant to that part.

[3] *See* Docket No. RM2008–1, Final Rules Establishing Appropriate Confidentiality Procedures, June 19, 2009. 74 FR 30938 (June 29, 2009).

III. Section-by-Section Analysis of Changes

Section 3004.1 Purpose. In proposed rule 3004.1 the original language of paragraph (a) is modified to better describe the function of the rules devoted to implementing FOIA. The information in paragraph (b) is updated to state that certain information is available on the Commission's Web site rather than in the electronic reading room or elsewhere on the site.

Section 3004.2 Presumption of openness. Proposed rule 3004.2 is added to recognize the ''presumption of openness'' mandated by the President and further explained by the Attorney General and Department of Justice.

Section 3004.10 Public records. Proposed rule 3004.10 replaces sections 3001.42(b)(1) through (b)(11). The information contained in section 3001.42(b) does not change, although the paragraphs are relabeled. For example, paragraph (b)(1) becomes paragraph (a) and paragraph (b)(2) becomes paragraph (b). Currently, section 3001.42(b)(2) is lengthy and contains a long list separated by commas. To make the information in the list easier to find, section 3001.42(b)(2) is divided into paragraphs (b)(1) through (7) of proposed rule 3004.10. Finally, the statement that offers of settlement are not public would be deleted as it is repeated in section 3001.42(b)(13)(ii).

Section 3004.11 Non-public records. Proposed rule 3004.11 replaces paragraphs (b)(12) and (13) of section 3001.42. Paragraphs (i) through (vii) of section 3001.42(b)(12) are redesignated as proposed rule 3004.11(a) through (g), and section 3001.42(b)(13) is redesignated as proposed rule 3004.11(h).

Section 3004.12 Reading room. Proposed rule 3004.12 contains the same substantive information as current rule 3004.2. The information contained in section 3004.2(c), which concerns the electronic reading room, is divided into proposed rule 3004.12(a) and (b). Proposed paragraph (a) indicates that the Commission has two reading rooms—one at its offices and one on its Web site. Proposed paragraph (b) lists examples of materials accessible in the reading rooms.

Section 3004.13 Notice and publication of public information. Current section 3001.42(a) is redesignated as proposed rule 3004.13, and is divided into two paragraphs—one concerning the availability and service of Commission rulings, decisions and reports, and the second regarding the availability of the Commission's guiding principles.

Section 3004.20 Commission procedure when served a subpoena. This proposed rule sets forth the procedure the Commission or its officers or employees shall follow when served with a subpoena for materials which are not public files or records. It requires that service of the subpoena shall be immediately reported to the Commission, along with a statement of relevant facts, and the Commission shall take the appropriate action to respond to the subpoena.

Section 3004.30 Relationship among the Freedom of Information Act, the Privacy Act, and the Commission's procedures for according appropriate confidentiality. Proposed rule 3004.30 replaces sections 3004.1(b) and 3004.6(c)(1)(v). The proposed rule is amended to include a reference to the Commission's rules governing the treatment of non-public materials, and the policy of referring a FOIA request for Postal Service records to the Postal Service.

Section 3004.40 Hard copy requests for records and for expedited processing. Section 3004.3, which governs the contents of requests for information made to the Commission under FOIA, is redesignated as proposed rule 3004.40. Paragraph (a) is divided into six paragraphs (a)(1) through (a)(6) to clearly delineate the requirements for hard copy requests, including a new requirement that the requester identify the category of request under proposed rule 3004.51. The substantive information in paragraphs (b) and (c) is consolidated into proposed paragraph (b) and rewritten to make the regulations more clear.

Section 3004.41 Electronic requests for records and for expedited processing. Proposed rule 3004.41 sets forth the requirements for electronically submitted requests for information made to the Commission under FOIA. The rule contains similar requirements to proposed rule 3004.40, but requires that the electronic request utilize the form for FOIA requests on the Commission's Web site.

Section 3004.42 Tracking of requests. Proposed rule 3004.42 is

added to reflect an amendment to FOIA which requires that agencies provide a tracking number and mechanism to monitor requests that take longer than 10 days to complete.

Section 3004.43 Response to requests. Proposed rule 3004.43 explains the Commission's actions upon receiving a request. Currently, the information in this proposed regulation is found in section 3004.3. The information contained in paragraph (a) is reorganized in multiple paragraphs within proposed rule 3004.43. Paragraph (c) is added to require that partial disclosures shall be made, if feasible, when a full disclosure is not possible. Former section 3004.3(b) contains superfluous information and is deleted. Paragraph (f) is added to proposed rule 3004.43 replacing section 3004.3(d).

Section 3004.44 Appeals. Proposed rule 3004.44 replaces section 3004.5(a). The substantive information in paragraph (a) is reorganized into three paragraphs to simplify the regulations.

Section 3004.45 Extension of response time limit. The information currently in section 3004.4(d) and section 3004.5(b) is consolidated and reorganized into two paragraphs in proposed rule 3004.45.

Section 3004.50 Fees-—definitions as used in this part. Current section 3004.6(a) is redesignated as proposed rule 3004.50. In addition, rather than making each definition its own paragraph as in section 3004.6(a), the definitions are arranged in alphabetical order without any paragraph designation. This allows definitions to be added alphabetically in the future without a redesignation of paragraphs. The definition of ''Representative of the news media'' is modified to conform with an amendment to the definition in the statute.

Section 3004.51 Fees—category of requests. The fees the Commission charges for processing FOIA requests are determined by the category of the requester—commercial, educational and scientific, news media, and other. Proposed rule 3004.53 replaces section 3004.6(c)(1) in identifying the processing fees for each type of requester. The language of sections 3004.6(c)(1)(i) through (iv) is not modified, although titles identifying the category of user are added to each paragraph. Section 3004.6(c)(1)(v) is rewritten to clarify the types of fees.

Section 3004.52 Fees—general provisions. Proposed rule 3004.52 consolidates general fee information currently found in sections 3004.6(b), (c)(2)(i), and (f). The part of section 3004.6(c)(2)(i) that explains that the Commission may charge for conducting a search even if no records are found or the records located are exempt from disclosure is relocated to proposed rule 3004.53(a). The information in section 3004.6(b) is moved to proposed rule 3004.52(b) and (c). Paragraph (f) is redesignated as proposed rule 3004.52(d). Proposed rule 3004.52(e) is added to reflect a change in the statute which does not allow an agency to recover fees if it fails to comply with time limits imposed by the statute. However, paragraph (e) does allow the Commission to charge fees for a partial disclosure while review continues on other sensitive records which may be responsive to the request.

Section 3004.53 Fee schedule. Section 3004.6(c)(2) is redesignated as proposed rule 3004.53.

Section 3004.54 Procedure for assessing and collecting fees. Proposed rule 3004.54 explains the Commission's assessment of interest and the circumstances under which the Commission requires advance payment of fees. Currently, the information in this proposed rule can be found in section 3004.3. Section 3004.6(e) is replaced by proposed rule 3004.54(a), which edits the original text to clarify the information. Paragraph (d) of section 3004.6 is redesignated as proposed rule 3004.54(b).

Section 3004.60 Freedom of Information Act public liaison. Proposed rule 3004.60 is added to designate the Director of the Office of Public Affairs and Government Relations as the FOIA Public Liaison. The FOIA Public Liaison provides an avenue for the public to informally resolve FOIA disputes with the Commission.

Section 3004.70 Submission of business information. Section 3004.8 is redesignated as proposed rule 3004.70. Titles are added to each paragraph to clarify the information contained therein. Proposed rule 3004.70(a) is added to indicate the overlap between this rule and application for non-public treatment pursuant to part 3007.

IV. Public Representative

Pursuant to 39 U.S.C. 505, Jeremy L. Simmons is appointed the officer of the Commission (Public Representative) to represent the interests of the general public in the captioned docket.

V. Ordering Paragraphs

It is ordered:

1. Docket No. RM2009–6 is established for the purpose of amending the Commission's rules governing the Freedom of Information Act.

2. Pursuant to 39 U.S.C. 505, Jeremy L. Simmons is appointed to serve as officer of the Commission (Public Representative) to represent the interests of the general public in these proceedings.

3. Interested persons may submit initial comments no later than 30 days from the date of publication of this notice in the **Federal Register**.

4. Reply comments may be filed no later than 45 days from the date of publication of this notice in the **Federal Register**.

5. The Secretary shall arrange for publication of this Notice in the **Federal Register**.

List of Subjects

39 CFR Part 3001

Administrative practice and procedure, Confidential business information, Postal Service.

39 CFR Part 3004

Administrative practice and procedure, Archives and records, Freedom of information, Organization, Privacy, Reporting and recordkeeping requirements.

By the Commission.

Judith M. Grady,

Acting Secretary.

For the reasons stated in the preamble, under the authority at 39 U.S.C. 504, the Postal Regulatory Commission proposes to amend 39 CFR chapter III as follows:

PART 3001—RULES OF PRACTICE AND PROCEDURE

1. The authority citation for Part 3001 continues to read as follows:

Authority: 39 U.S.C. 404(d) 503; 3661.

§ 3001.42 [Removed]

2. Remove § 3001.42 in its entirety.

PART 3004—PUBLIC RECORDS AND FREEDOM OF INFORMATION ACT

3. Part 3004 is revised to read as follows:

PART 3004—PUBLIC RECORDS AND FREEDOM OF INFORMATION ACT

Sec.

Authority: 5 U.S.C. 552; 39 U.S.C. 503.

§ 3004.1 Purpose.

(a) This part implements the Freedom of Information Act (FOIA), 5 U.S.C. 552, and describes the procedures by which a person may request copies of Commission records pursuant to FOIA. It contains the rules that the Commission follows in handling requests, such as the amount of time it has to make a determination regarding release of records and what fees to charge. It also describes how a submitter of trade secrets or confidential business information can identify information that the submitter believes to be exempt from disclosure under 5 U.S.C. 552(b).

(b) Information required to be published or made available pursuant to 5 U.S.C. 552(a)(1) and (a)(2) may be found in 39 CFR part 3002, in the **Federal Register**, or on the Commission's Web site at *http://www.prc.gov*. The Commission's guide to FOIA, all required FOIA indexes, and any available annual FOIA reports are also available on the Web site.

(c) Section 3004.10 identifies records that the Commission has determined to be public.

§ 3004.2 Presumption of openness.

(a) The Commission shall be proactive and systematically, in a timely manner, post public records online in advance of any public request.

(b) It is the stated policy of the Commission that FOIA requests shall be administered with a clear presumption of openness.

§ 3004.10 Public records.

(a) Except as provided in § 3004.11 and in § 3007.10 of this chapter, the public records of the Commission include all submissions and filings as follows:

(1) Requests of the Postal Service for decisions or advisory opinions, public reports, complaints (both formal and informal), and other papers seeking Commission action;

(2) Financial, statistical and other reports to the Commission, and other filings and submittals to the Commission in compliance with the requirements of any statute, executive order, or Commission rule, regulation or order;

(3) All answers, replies, responses, objections, protests, motions, stipulations, exceptions, other pleadings, notices, depositions, certificates, proofs of service, transcripts and briefs in any matter or proceeding;

(4) Exhibits, attachments and appendices to, amendments and corrections of, supplements to, or transmittals or withdrawals of any of the foregoing; and

(5) Commission correspondence related to the foregoing.

(b) All other parts of the formal record in any matter or proceeding set for formal or statutory hearing and any Commission correspondence related thereto, including:

(1) Notices or Commission orders initiating the matter or proceeding;

(2) Designation of the presiding officer;

(3) Transcript of hearings;

(4) Offers of proof, motions and stipulations made during a hearing;

(5) Exhibits received in evidence during a hearing;

(6) Certifications to the Commission; and

(7) Anything else upon which action of a presiding officer or the Commission may be based.

(c) Proposed testimony or exhibit filed with the Commission but not yet offered or received in evidence.

(d) Presiding officer actions and all presiding officer correspondence and memoranda to or from anyone other than staff assigned to provide assistance to the presiding officer.

(e) Commission decisions, reports, opinions, orders, notices, findings, determinations and other actions in any matter or proceeding and all Commission minutes which have been approved.

(f) Commission correspondence relating to any furnishing of data or information by the Postal Service.

(g) Commission correspondence with respect to the furnishing of data, information, comments or recommendations to or by another branch, department, or agency of the Government where furnished to satisfy a specific requirement of a statute or where made public by that branch, department or agency.

(h) Commission correspondence and reports on legislative matters under consideration by the Office of Management and Budget or Congress, but only if and after authorized for release or publication by that office, the Commission or the Member of Congress involved.

(i) Commission correspondence on the interpretation or applicability of any statute, rule, regulation, decision, advisory opinion or public report issued by the Commission and letters of opinion on that subject signed by the General Counsel and sent to persons other than the Commission, a Commissioner or any of the staff.

(j) Copies of all filings by the Commission, and all orders, judgments, decrees and mandates directed to the Commission in court proceedings involving Commission action and all correspondence with the courts or clerks of court.

(k) The Commission's administrative and operating manuals as issued.

§ 3004.11 Non-public records.

(a) The public records of the Commission do not include records that are:

(1) Specifically authorized under criteria established by an executive order to be kept secret in the interest of national defense or foreign policy and, in fact, properly classified pursuant to such executive order;

(2) Related solely to the internal personnel rules and practices of the Commission;

(3) Specifically exempted from disclosure by statute;

(4) Trade secrets and commercial or financial information obtained from a person and privileged or confidential;

(5) Interagency or intra-agency memoranda or letters which would not be available by law to a party other than a person or entity in litigation with the Commission;

(6) Personnel and medical files and similar files, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy; and

(7) Investigatory records compiled for law enforcement purposes to the extent specified in 5 U.S.C. 552(b)(7).

(b) The following are examples of information that are not part of the public records of the Commission:

(1) Written communications between or among the Commission, members of the Commission, the Secretary, and expressly designated members of the staff while particularly assigned, in accordance with all applicable legal requirements, to aid the Commission in the drafting of any decision, advisory opinion, or public report and findings, with or without opinion, or report in any matter or proceeding;

(2) Reports and records compiled or created by the Inspector General of the Commission designated as confidential; and

(3) Unaccepted offers of settlement in any matter or proceeding unless or until made public by act of the offeror.

§ 3004.12 Reading room.

(a) The Commission maintains a public reading room at its offices (901 New York Avenue, NW., Suite 200, Washington, DC 20268–0001) and an electronic reading room at *http://www.prc.gov*. The public reading room at its offices is open during business hours.

(b) The records available for public inspection and printing include, for example, decisions; reports; opinions; orders; notices; findings; determinations; statements of policy; copies of selected records released under FOIA; indexes required to be maintained under FOIA; and records described in § 3004.10 relating to any matter or proceeding before the Commission.

§ 3004.13 Notice and publication of public information.

(a) Decisions, advisory opinions, orders and public reports will be made available to the public by posting on the Commission's Web site at *http://www.prc.gov* and will be served upon parties to the proceedings in accordance with 3001.9 through 3001.12.

(b) Descriptions of the Commission's organization, its methods of operation, statements of policy and interpretations, procedural and substantive rules, and amendments thereto are published in the **Federal Register**, and are available on the Commission's Web site, *http://www.prc.gov*.

§ 3004.20 Commission procedure when served a subpoena.

If an officer or employee of the Commission is served with a subpoena duces tecum, material that is not part of the public files and records of the Commission shall be produced only as authorized by the Commission. Service of such a subpoena shall immediately be reported to the Commission with a statement of all relevant facts. The Commission will thereupon enter such order or give such instructions as it deems advisable.

§ 3004.30 Relationship among the Freedom of Information Act, the Privacy Act, and the Commission's procedures for according appropriate confidentiality.

(a) *Coverage.* FOIA applies to all Commission records and provides the public with access to government records.

(b) *Requesting records subject to the Privacy Act.* A request by an individual for his or her own records contained in a system of records will be considered under the Privacy Act pursuant to part 3003 of this chapter. If there is any record that the Commission need not release to such individual under those provisions, the Commission will also consider that request under FOIA, and will release the record if FOIA requires it.

(c) *Requesting another individual's record.* Request for records of individuals which may not be granted under the Privacy Act shall be considered under FOIA.

(1) If the Commission makes a disclosure in response to a request and the disclosure is permitted by the Privacy Act's disclosure provision, 5 U.S.C. 552a(b), the Commission will rely on the Privacy Act to govern the disclosure.

(2) In some circumstances, the Privacy Act may prohibit the Commission's ability to release records which may be released under FOIA.

(d) *Requesting a Postal Service record.* The Commission maintains custody of Postal Service records.

(1) Postal Service records which are covered by the Commission's treatment of non-public materials under part 3007 of this chapter may be requested following the procedures set forth in that part.

(2) A request to the Commission for Postal Service records via a Freedom of Information Act request pursuant to 5 U.S.C. 552 shall be referred to the Postal Service.

§ 3004.40 Hard copy requests for records and for expedited processing.

(a) A hard copy request for records must:

(1) Be in writing;

(2) Reasonably describe the records sought;

(3) Include a daytime telephone number;

(4) Be clearly identified as ''Freedom of Information Act Request'' both in the text of the request and on the envelope;

(5) Identify the category of requester under § 3004.51; and

(6) Be submitted to the Secretary of the Commission at the offices of the Commission (901 New York Avenue, NW., Suite 200, Washington, DC 20268–0001).

(b) *Expedited processing.* A person demonstrating a compelling need as defined in 5 U.S.C. 552(a)(6)(E)(v) may request expedited processing at the time of an initial request (or appeal) or at a later time. In addition to the requirements in paragraph (a) of this section, an expedited request for records must:

(1) Demonstrate a compelling need as defined in 5 U.S.C. 552(a)(6)(E)(v);

(2) Be clearly identified as ''Expedited Freedom of Information Act Request'' both in the text of the request and on the envelope; and

(3) Certify the statement of compelling need to be true and correct to the best of the requester's knowledge and belief. At its discretion, the Commission may waive the requirement for certification.

§ 3004.41 Electronic requests for records and for expedited processing.

(a) An electronic request for records must:

(1) Be made via the Commission's online FOIA request form at *http://www.prc.gov*;

(2) Reasonably describe the records sought;

(3) Include a daytime telephone number and valid e-mail address; and

(4) Identify the category of requester under § 3004.51.

(b) *Expedited processing.* A person satisfying the requirements of subsection (a) may request expedited processing at the time of the initial request or at a later time by:

(1) Demonstrating a compelling need as defined in 5 U.S.C. 552(a)(6)(E)(v);

(2) Clearly identifying the request as an ''Expedited Freedom of Information Act Request'' in the body of the submission; and

(3) Certifying the statement of compelling need to be true and correct to the best of the requester's knowledge and belief. At its discretion, the Commission may waive the requirement for certification.

§ 3004.42 Tracking of requests.

(a) Upon receipt of a request, the Commission shall assign a unique tracking number to the request and within 3 days (excluding Saturdays, Sundays and legal holidays) and provide that number to the person making the request.

(b) Any person with a tracking number may call or e-mail the Commission's Office of Public Affairs and Government Relations (PAGR) to check the status of a request. PAGR may be e-mailed at *PRC-PAGR@prc.gov* or called at 202–789–6800.

§ 3004.43 Response to requests.

(a) Within 20 days (excluding Saturdays, Sundays and legal holidays) after receipt of a request for a Commission record, the Secretary of the Commission will notify the requester of its determination to grant or deny the request.

(b) *Granting request.* If granting the request, the Commission will notify the requester of any fees that must be paid.

(c) *Partial granting of request.* If the Commission is unable to grant the request in its entirety, any reasonably segregable portion of the request shall be provided, with deleted portions treated as specified in paragraph (d) of this section, and the Commission will notify the requester of any fees that must be paid.

(d) *Denying request.* If denying the request, in whole or in part, the Commission will inform the requester in writing of:

(1) The reason for the denial, including each exemption used as a basis for withholding of the records sought and, if applicable, the harm to an interest protected by a statutory exemption;

(2) An estimate of the volume of requested matter that was denied:

(i) If disclosure of a record has been partially denied, the amount of information deleted will be indicated on the released portion if technically feasible; and

(ii) If revealing the amount or location of a denied record will harm an interest protected by an exemption, then the description of the amount or location of deleted information shall be withheld.

(3) The right to appeal the denial to the Commission within 1 year.

(e) *Expedited processing.* Within 10 days (excluding Saturdays, Sundays and legal holidays) after receipt of a request for expedited processing, the Secretary of the Commission will:

(1) Grant the request for expedited processing and process the request for records as soon as practicable; or

(2) Deny the request for expedited processing by informing the individual of:

(i) The denial in writing;

(ii) The right to appeal the denial to the Commission in writing; and

(iii) The procedures for appealing the denial.

(3) Any request for records that has been denied expedited processing will be processed in the same manner as a request that did not seek expedited processing.

(f) Where a compelling need is not shown in an expedited request as specified in § 3004.21(b)(1), the Commission may grant requests for expedited processing at its discretion.

§ 3004.44 Appeals.

(a) The Commission may review any decision of the Secretary of the Commission on its own initiative.

(b) A requester who seeks to appeal any denial must file an appeal with the Commission.

(c) Response to appeal.

(1) The Commission will grant or deny the appeal in writing within 20 days (excluding Saturdays, Sundays and legal holidays) of the date the appeal is received. If on appeal the denial of the request for records is upheld, the Commission will notify the requester of the provisions for judicial review of that determination pursuant to 5 U.S.C. 552(c).

(2) The Commission will expeditiously consider an appeal of a denial of expedited processing.

§ 3004.45 Extension of response time limit.

(a) The Commission may extend the time limit for a response at the request stage and at the appeal stage up to 10 working days due to unusual circumstances as specified in 5 U.S.C. 552(a)(6)(B)(iii).

(b) The Commission will:

(1) Notify the requester of any extension and the reason for the extension in writing; and

(2) Provide the requester with an opportunity to limit the scope of the request or to arrange an alternative timeframe for processing the request or a modified request. The applicable time limits are not tolled while the Commission waits for a response from the requester under this subsection.

§ 3004.50 Fees—definitions as used in this part.

Commercial use means a request from or on behalf of a person seeking information for a use or purpose that furthers the commercial, trade, or profit interests of the requester or person on whose behalf the request is made. In determining the applicability of this term, the use to which a requester will put the document is considered first; where reasonable doubt exists as to the use, the Commission may seek clarification before assigning the request to a category.

Direct costs means the expenditures the Commission incurs in searching for, duplicating, and, where applicable, reviewing documents to respond to a request. They include (without limitation) the salary of the employee(s) performing work (the basic pay rate of such employee(s) plus 16 percent to cover benefits).

Duplication means copying the documents necessary to respond to a request. Such copies may be paper, microform, audiovisual, or machine-readable.

Educational institution means a preschool, a public or private elementary or secondary school, an institution of graduate or undergraduate higher education, an institution of professional education, and an institution of vocational education, which operates a program or programs of scholarly research.

Noncommercial scientific institution means an institution, not operated on a commercial basis (as referenced above), which is operated solely for the purpose of conducting scientific research whose results are not intended to promote any particular product or industry.

Representative of the news media means any person or entity that gathers information of potential interest to a segment of the public, uses its editorial skills to turn the raw materials into a distinct work, and distributes that work to an audience. The term ''news'' means information that is about current events or that would be of current interest to the public. Examples of news media entities are television or radio stations broadcasting to the public at large and publishers of periodicals (but only if such entities qualify as disseminators of ''news'') who make their products available for purchase or by subscription or by free distribution to the general public. These examples are not all inclusive and may include alternate media to disseminate news. A freelance journalist shall be regarded as working for a news media entity if the journalist can demonstrate a solid basis for expecting publication through that entity (*e.g.*, by a publication contract or prior publication record), whether or not the journalist is actually employed by the entity.

Review means examining documents located in response to a commercial use request to determine whether any portion is exempt from disclosure, and processing or preparing documents for release, but not determination of general legal or policy issues regarding application of exemptions.

Search includes all time spent looking for material responsive to a request, including identification of pages or lines within documents. The term covers both manual and computerized searching.

§ 3004.51 Fees—category of requests.

(a) The level of fee charged depends on the category of requester.

(1) *Commercial use.* A request appearing to be for commercial use will be charged the full direct costs of searching for, reviewing and duplicating the records sought.

(2) *Educational and noncommercial scientific institutions.* A request from an educational or noncommercial scientific institution will be charged for the cost of duplication only (excluding charges for the first 100 pages). To be eligible for this category, a requester must show that the request is made under the

auspices of a qualifying institution and that the records are not sought for commercial use but are in furtherance of scholarly (in the case of educational institutions) or scientific (in the case of noncommercial scientific institutions) research.

(3) *News media.* A request from a representative of the news media will be charged the cost of duplication only (excluding charges for the first 100 pages).

(4) *Other requesters.* A request from any other person will be charged the full direct cost of searching for, review of, and duplicating records responsive to the request, except that the first 100 pages of duplication and the first 2 hours of search will be furnished without charge.

(b) *Privacy Act.* A request by an individual for his or her own records in a system of records will be charged fees as provided under the Commission's Privacy Act regulations in part 3003 of this chapter.

§ 3004.52 Fees—general provisions.

(a) The Commission may charge search fees even if no records are found or if the records found are exempt from disclosure.

(b) Except in the case of commercial use requesters, the first 100 pages of duplication and the first 2 hours of search time are provided without charge.

(1) A page for these purposes is a letter- or legal-size sheet, or the equivalent amount of information in a medium other than paper copy.

(2) Search time for these purposes refers to manual searching; if the search is performed by computer, the 2 hours provided without charge will be equal to 2 hours' salary of the person performing the search.

(c) No requester will be charged a fee when the Commission determines that the cost of collecting the fee would equal or exceed the fee itself. In determining whether cost of collection would equal or exceed the fee, the allowance for 2 hours' search or 100 pages of duplication will be made before comparing the remaining fee and the cost of collection.

(d) Records will be provided without charge or at a reduced charge if disclosure of the information is in the public interest because it is likely to contribute significantly to public understanding of the operations or activities of the government and is not primarily in the commercial interest of the requester.

(e) No requester will be charged a fee after any search or response which occurs after the applicable time limits as described in §§ 3004.42 and 3004.44, so long as there are no unusual or exceptional circumstances, such as those used to justify an extension of the time limit as described in § 3004.44. The Commission may, however, charge fees for a partial grant of a request while it reviews other sensitive records, which may be responsive to the request, if it is made within the applicable time limits.

§ 3004.53 Fee schedule.

(a) Fees will be calculated as follows:

(1) *Manual search.* At the salary rate (basic pay plus 16 percent) of the employee(s) making the search. Search time may be charged for even if the Commission fails to locate records or if records located are exempt from disclosure.

(2) *Computer search.* At the direct cost of providing the search, including computer search time directly attributable to searching for records responsive to the request runs and operator salary apportionable to the search.

(3) *Review (commercial use).* At the salary rate (basic pay plus 16 percent) of the employee(s) conducting the review. Charges are imposed only for the review necessary at the initial administrative level to determine the applicability of any exemption, and not for review at the administrative appeal level of an exemption already applied.

(4) *Duplication.* At 15 cents per page for paper copy, which the Commission has found to be the reasonable direct cost thereof. For copies of records prepared by computer (such as tapes or printouts), the actually incurred cost of production, including employee time, will be charged.

(5) *Additional services.* Postage, insurance, and other additional services that may be arranged for by the requester will be charged at actually incurred cost.

(b) Fees may be waived at the discretion of the Commission.

§ 3004.54 Procedure for assessing and collecting fees.

(a) Advance payment may be required if the requester failed to pay previous bills in a timely fashion or when the fees are likely to exceed $250.

(1) Where the requester has previously failed to pay within 30 days of the billing date, the Commission may require the requester to pay an advance payment of the estimated fee together with either the past due fees (plus applicable interest) or proof that the past fees were paid.

(2) When advance payment is required, the administrative time limits prescribed in 5 U.S.C. 552(a)(6) (§ 3004.42) begin only after such payment has been received.

(b) Interest at the rate published by the Secretary of the Treasury as prescribed in 31 U.S.C. 3717 will be charged on unpaid fee bills starting on the 31st day after the bill was sent. Receipt of a fee by the Commission, whether processed or not, will stay the accrual of interest.

§ 3004.60 Freedom of Information Act Public Liaison.

The Commission designates the Director of the Office of Public Affairs and Government Relations as the FOIA Public Liaison who shall assist in the resolution of any dispute between a requester and the Commission. The FOIA Public Liaison may be contacted via e-mail at *PRC-PAGR@prc.gov* or telephone at 202–789–6800.

§ 3004.70 Submission of business information.

(a) *Overlap with treatment of non-public materials.* Any person who submits materials to the Commission (submitter) that the person reasonably believes to be exempt from public disclosure may submit materials under seal and lodge an application for non-public treatment as described in § 3007.10.

(b) *Notice of request.* If a FOIA request seeks materials designated as exempt from public disclosure, the Commission will provide the submitter with notice of the request. The Commission may also provide notice when it has reason to believe that business information possibly exempt from disclosure may fall within the scope of any FOIA request.

(c) *Objections to disclosure.* A submitter may file written objections to the request specifying all grounds for withholding the information under FOIA within 7 days of the date of the notice. If the submitter fails to respond to the notice, the submitter will be considered to have no objection to the disclosure of the information.

(d) *Notice of decision.* If, after considering the submitter's objections to disclosure the Commission decides to disclose the information, it will give the submitter written notice of the decision and a brief explanation of the reasons for not sustaining the submitter's objections. The actual disclosure will not be made before 3 days after the submitter has received the notice.

[FR Doc. E9–16417 Filed 7–10–09; 8:45 am]

BILLING CODE 7710–FW–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA–R03–OAR–2009–0352; FRL–8929–3]

Approval and Promulgation of Air Quality Implementation Plans; Pennsylvania; Allegheny County, Continuous Opacity Monitor Regulation

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: EPA proposes to approve the State Implementation Plan (SIP) revision submitted by the Commonwealth of Pennsylvania for the purpose of establishing the method to determine compliance with opacity requirements for coke oven combustion stacks in Allegheny County, allowing the use of continuous opacity monitoring systems (COMS) to measure visible emissions in Allegheny County, and removing a redundant phrase in the current approved SIP. In the Final Rules section of this **Federal Register**, EPA is approving the Commonwealth's SIP submittal as a direct final rule without prior proposal because the Agency views this as a noncontroversial submittal and anticipates no adverse comments. A detailed rationale for the approval is set forth in the direct final rule. If no adverse comments are received in response to this action, no further activity is contemplated. If EPA receives adverse comments, the direct final rule will be withdrawn and all public comments received will be addressed in a subsequent final rule based on this proposed rule. EPA will not institute a second comment period. Any parties interested in commenting on this action should do so at this time.

DATES: Comments must be received in writing by August 12, 2009.

ADDRESSES: Submit your comments, identified by Docket ID Number EPA–R03–OAR–2009–0352 by one of the following methods:

A. *http://www.regulations.gov*. Follow the online instructions for submitting comments.

B. *E-mail: fernadez.cristina@epa.gov*.

C. *Mail:* EPA–R03–OAR–2009–0352, Cristina Fernandez, Chief, Air Quality Planning Branch, Mailcode 3AP21, U.S. Environmental Protection Agency, Region III, 1650 Arch Street, Philadelphia, Pennsylvania 19103.

D. *Hand Delivery:* At the previously-listed EPA Region III address. Such deliveries are only accepted during the Docket's normal hours of operation, and special arrangements should be made for deliveries of boxed information.

Instructions: Direct your comments to Docket ID No. EPA–R03–OAR–2009–0352. EPA's policy is that all comments received will be included in the public docket without change, and may be made available online at *http://www.regulations.gov*, including any personal information provided, unless the comment includes information claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Do not submit information that you consider to be CBI or otherwise protected through *http://www.regulations.gov* or e-mail. The *http://www.regulations.gov* Web site is an ''anonymous access'' system, which means EPA will not know your identity or contact information unless you provide it in the body of your comment. If you send an e-mail comment directly to EPA without going through *http://www.regulations.gov*, your e-mail address will be automatically captured and included as part of the comment that is placed in the public docket and made available on the Internet. If you submit an electronic comment, EPA recommends that you include your name and other contact information in the body of your comment and with any disk or CD-ROM you submit. If EPA cannot read your comment due to technical difficulties and cannot contact you for clarification, EPA may not be able to consider your comment. Electronic files should avoid the use of special characters, any form of encryption, and be free of any defects or viruses.

Docket: All documents in the electronic docket are listed in the *http://www.regulations.gov* index. Although listed in the index, some information is not publicly available, i.e., CBI or other information whose disclosure is restricted by statute. Certain other material, such as copyrighted material, is not placed on the Internet and will be publicly available only in hard copy form. Publicly available docket materials are available either electronically in *http://www.regulations.gov* or in hard copy during normal business hours at the Air Protection Division, U.S. Environmental Protection Agency, Region III, 1650 Arch Street, Philadelphia, Pennsylvania 19103. Copies of the State submittal are available at the Allegheny County Health Department, Bureau of Environmental Quality, Division of Air Quality, 301 39th Street, Pittsburgh, Pennsylvania 15201.

FOR FURTHER INFORMATION CONTACT: Maria A. Pino, (215) 814–2181, or by e-mail at *pino.maria@epa.gov*.

SUPPLEMENTARY INFORMATION: For further information on this SIP revision, which revises the Pennsylvania SIP to establish the method to determine compliance with opacity requirements for coke oven combustion stacks and allows the use of COMS to measure visible emissions in Allegheny County, and removes a redundant phrase in the current approved SIP, please see the information provided in the direct final action, with the same title, that is located in the ''Rules and Regulations'' section of this **Federal Register** publication. Please note that if EPA receives adverse comment on an amendment, paragraph, or section of this rule and if that provision may be severed from the remainder of the rule, EPA may adopt as final those provisions of the rule that are not the subject of an adverse comment.

Dated: July 1, 2009.

William C. Early,

Acting Regional Administrator, Region III.

[FR Doc. E9–16363 Filed 7–10–09; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA–R09–OAR–2009–0384; FRL–8929–8]

Revisions to the California State Implementation Plan

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: EPA is proposing to approve revisions to the San Joaquin Valley Unified Air Pollution Control District (SJUVAPCD) portion of the California State Implementation Plan (SIP). These revisions concern oxides of nitrogen (NO_X) emissions from Stationary Gas Turbines. We are approving a local rule that regulates these emission sources under the Clean Air Act as amended in 1990 (CAA or the Act). We are taking comments on this proposal and plan to follow with a final action.

DATES: Any comments must arrive by August 12, 2009.

ADDRESSES: Submit comments, identified by docket number EPA–R09–OAR–2009–0384, by one of the following methods:

1. *Federal eRulemaking Portal: http://www.regulations.gov*. Follow the online instructions.

2. *E-mail: steckel.andrew@epa.gov*.

3. *Mail or deliver:* Andrew Steckel (Air–4), U.S. Environmental Protection Agency Region IX, 75 Hawthorne Street, San Francisco, CA 94105–3901.

Instructions: All comments will be included in the public docket without change and may be made available online at *http://www.regulations.gov*, including any personal information provided, unless the comment includes Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Information that you consider CBI or otherwise protected should be clearly identified as such and should not be submitted through *http://www.regulations.gov* or e-mail. *http://www.regulations.gov* is an ''anonymous access'' system, and EPA will not know your identity or contact information unless you provide it in the body of your comment. If you send e-mail directly to EPA, your e-mail address will be automatically captured and included as part of the public comment. If EPA cannot read your comment due to technical difficulties and cannot contact you for clarification, EPA may not be able to consider your comment.

Docket: The index to the docket for this action is available electronically at *http://www.regulations.gov* and in hard copy at EPA Region IX, 75 Hawthorne Street, San Francisco, California. While all documents in the docket are listed in the index, some information may be publicly available only at the hard copy location (*e.g.*, copyrighted material), and some may not be publicly available in either location (*e.g.*, CBI). To inspect the hard copy materials, please schedule an appointment during normal business hours with the contact listed in the **FOR FURTHER INFORMATION CONTACT** section.

FOR FURTHER INFORMATION CONTACT: Idalia Perez, EPA Region IX, (415) 972–3248, *perez.idalia@epa.gov*.

SUPPLEMENTARY INFORMATION: Throughout this document, ''we,'' ''us'' and ''our'' refer to EPA.

Table of Contents

I. The State's Submittal

A. What rule did the State submit?

Table 1 lists the rule addressed by this proposal with the date that it was adopted by the local air agency and submitted by the California Air Resources Board (CARB).

TABLE 1—SUBMITTED RULES

Local agency	Rule #	Rule title	Adopted	Submitted
SJVUAPCD	4703	Stationary Gas Turbines	09/20/07	03/07/08

On April 17, 2008, this rule submittal was found to meet the completeness criteria in 40 CFR Part 51, Appendix V, which must be met before formal EPA review.

B. Are there other versions of this rule?

We approved a version of Rule 4703 into the SIP on May 18, 2004. The SJVUAPCD adopted an earlier revision to the SIP-approved version on August 17, 2006 and CARB submitted it to us on December 29, 2006. While we can act on only the most recently submitted version, we have reviewed materials provided with previous submittal.

C. What is the purpose of the submitted rule revision?

NO_X helps produce ground-level ozone, smog and particulate matter, which harm human health and the environment. Section 110(a) of the CAA requires States to submit regulations that control NO_X emissions. Rule 4703 regulates emissions of oxides of nitrogen (NO_X) and carbon monoxide (CO) from stationary gas turbine systems with ratings equal to or greater than 0.3 MW or a maximum heat input rating greater than 3 million Btu/hr. The Rule was revised to include more stringent emission limits and eliminate some exemptions present in the SIP-approved version. EPA's technical support document (TSD) has more information about this rule.

II. EPA's Evaluation and Action

A. How is EPA evaluating the rule?

Generally, SIP rules must be enforceable (see section 110(a) of the Act), must require Reasonably Available Control Technology (RACT) for each category of sources covered by a Control Techniques Guidelines (CTG) document as well as each major source in nonattainment areas (see sections 182(a)(2) and 182(f)), and must not relax existing requirements (see sections 110(l) and 193). The SJVUAPCD regulates an ozone nonattainment area (see 40 CFR part 81), so Rule 4703 must fulfill RACT.

Guidance and policy documents that we use to help evaluate enforceability and RACT requirements consistently include the following:

1. ''State Implementation Plans; Nitrogen Oxides Supplement to the General Preamble; Clean Air Act Amendments of 1990 Implementation of Title I; Proposed Rule,'' (the NO_X Supplement), 57 FR 55620, November 25, 1992.

2. ''Issues Relating to VOC Regulation Cutpoints, Deficiencies, and Deviations,'' EPA, May 25, 1988 (the Bluebook).

3. ''Guidance Document for Correcting Common VOC & Other Rule Deficiencies,'' EPA Region 9, August 21, 2001 (the Little Bluebook).

4. ''Improving Air Quality with Economic Incentive Programs,'' EPA, 452/R–01–001, January 2001.

5. ''Alternative Control Technology Document, NO_X Emissions from Stationary Gas Turbines,'' EPA, 453/R–93–007, January 1993.

B. Does the rule meet the evaluation criteria?

We believe this rule is consistent with the relevant policy and guidance regarding enforceability, RACT, and SIP relaxations. The TSD has more information on our evaluation.

C. EPA Recommendations To Further Improve the Rule

The TSD describes additional rule revisions that do not affect EPA's current action but are recommended for the next time the local agency modifies the rule.

D. Public Comment and Final Action

Because EPA believes the submitted rule fulfills all relevant requirements, we are proposing to fully approve it as described in section 110(k)(3) of the Act. We will accept comments from the public on this proposal for the next 30 days. Unless we receive convincing new

information during the comment period, we intend to publish a final approval action that will incorporate this rule into the Federally enforceable SIP.

III. Statutory and Executive Order Reviews

Under the Clean Air Act, the Administrator is required to approve a SIP submission that complies with the provisions of the Act and applicable Federal regulations. 42 U.S.C. 7410(k); 40 CFR 52.02(a). Thus, in reviewing SIP submissions, EPA's role is to approve state choices, provided that they meet the criteria of the Clean Air Act. Accordingly, this action merely approves state law as meeting Federal requirements and does not impose additional requirements beyond those imposed by State law. For that reason, this action:

- Is not a ''significant regulatory action'' subject to review by the Office of Management and Budget under Executive Order 12866 (58 FR 51735, October 4, 1993);
- Does not impose an information collection burden under the provisions of the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*);
- Is certified as not having a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*);
- Does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4);
- Does not have Federalism implications as specified in Executive Order 13132 (64 FR 43255, August 10, 1999);
- Is not an economically significant regulatory action based on health or safety risks subject to Executive Order 13045 (62 FR 19885, April 23, 1997);
- Is not a significant regulatory action subject to Executive Order 13211 (66 FR 28355, May 22, 2001);
- Is not subject to requirements of Section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) because application of those requirements would be inconsistent with the Clean Air Act; and
- Does not provide EPA with the discretionary authority to address, as appropriate, disproportionate human health or environmental effects, using practicable and legally permissible methods, under Executive Order 12898 (59 FR 7629, February 16, 1994).

In addition, this rule does not have tribal implications as specified by Executive Order 13175 (65 FR 67249, November 9, 2000), because the SIP is not approved to apply in Indian country located in the state, and EPA notes that it will not impose substantial direct costs on tribal governments or preempt tribal law.

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Intergovernmental relations, Nitrogen dioxide, Ozone, Reporting and recordkeeping requirements.

Authority: 42 U.S.C. 7401 *et seq.*

Dated: June 22, 2009.

Jane Diamond,

Acting Deputy Regional Administrator, Region IX.

[FR Doc. E9–16495 Filed 7–10–09; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA–R09–OAR–2009–0371, FRL–8929–7]

Revisions to the California State Implementation Plan, Northern Sierra Air Quality Management District and San Joaquin Valley Unified Air Pollution Control District

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: EPA is proposing to approve revisions to the Northern Sierra Air Quality Management District (NSAQMD) and San Joaquin Valley Unified Air Pollution Control District (SJVUAPCD) portions of the California State Implementation Plan (SIP). Under authority of the Clean Air Act as amended in 1990 (CAA or the Act), we are proposing to approve local rules that address volatile organic compound emissions from asphalt paving, gasoline bulk storage tanks, and gasoline dispensing stations.

DATES: Any comments must arrive by August 12, 2009.

ADDRESSES: Submit comments, identified by docket number EPA–R09–OAR–2009–0371, by one of the following methods:

1. *Federal eRulemaking Portal: http://www.regulations.gov*. Follow the on-line instructions.
2. *E-mail: steckel.andrew@epa.gov*.
3. *Mail or deliver:* Andrew Steckel (Air-4), U.S. Environmental Protection Agency Region IX, 75 Hawthorne Street, San Francisco, CA 94105–3901.

Instructions: All comments will be included in the public docket without change and may be made available online at *http://www.regulations.gov*, including any personal information provided, unless the comment includes Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Information that you consider CBI or otherwise protected should be clearly identified as such and should not be submitted through *http://www.regulations.gov* or e-mail. *http://www.regulations.gov* is an ''anonymous access'' system, and EPA will not know your identity or contact information unless you provide it in the body of your comment. If you send e-mail directly to EPA, your e-mail address will be automatically captured and included as part of the public comment. If EPA cannot read your comment due to technical difficulties and cannot contact you for clarification, EPA may not be able to consider your comment.

Docket: The index to the docket for this action is available electronically at *http://www.regulations.gov* and in hard copy at EPA Region IX, 75 Hawthorne Street, San Francisco, California. While all documents in the docket are listed in the index, some information may be publicly available only at the hard copy location (*e.g.*, copyrighted material), and some may not be publicly available in either location (*e.g.*, CBI). To inspect the hard copy materials, please schedule an appointment during normal business hours with the contact listed in the **FOR FURTHER INFORMATION CONTACT** section.

FOR FURTHER INFORMATION CONTACT: Mae Wang, EPA Region IX, (415) 947–4124, *wang.mae@epa.gov*.

SUPPLEMENTARY INFORMATION: Throughout this document, ''we,'' ''us'' and ''our'' refer to EPA.

Table of Contents

I. The State's Submittal

A. What Rules Did the State Submit?

Table 1 lists the rules we are proposing to approve with the dates that they were adopted, amended, or revised by the local air agencies and submitted by the California Air Resources Board (CARB).

TABLE 1—SUBMITTED RULES

District	Rule No.	Rule title	Adopted or amended	Submitted
NSAQMD	227	Cutback and Emulsified Asphalt Paving Materials	11/27/06	03/07/08
SJVUAPCD	4621	Gasoline Transfer into Stationary Storage Containers, Delivery Vessels, and Bulk Plants.	12/20/07	03/07/08
SJVUAPCD	4622	Gasoline Transfer into Motor Vehicle Fuel Tanks	12/20/07	03/07/08
SJVUAPCD	4651	Soil Decontamination Operations	09/20/07	03/07/08

On April 17, 2008, CARB's submittal of March 7, 2008, was found to meet the completeness criteria in 40 CFR part 51, appendix V, which must be met before formal EPA review.

B. Are There Other Versions of These Rules?

There is no previous version of NSAQMD Rule 227 in the SIP. We approved previous versions of SJVUAPCD Rules 4621 and 4622 into the SIP on April 19, 2000 (65 FR 20912) and March 24, 2003 (68 FR 14156), respectively. We approved a previous version of SJVUAPCD Rule 4651 into the SIP on July 24, 1996 (61 FR 38571).

C. What Is the Purpose of the Submitted Rules and Rule Amendments?

Volatile organic compounds (VOCs) help produce ground-level ozone and smog, which harm human health and the environment. Section 110(a) of the CAA requires States to submit regulations that control VOC emissions. NSAQMD Rule 227 provides standards to control VOC emissions during the use or manufacture of cutback asphalt and emulsified asphalt paving materials. SJVUAPCD Rule 4621 limits VOC emissions from gasoline storage containers and delivery vessels, and gasoline transfer operations at bulk plants. SJVUAPCD Rule 4622 limits VOC emissions from the transfer of gasoline into motor vehicle fuel tanks. SJVUAPCD Rule 4651 regulates VOC emissions from excavation, transportation, handling, decontamination, and disposal of soil that has been contaminated with a VOC-containing liquid. EPA's technical support documents (TSDs) have more information about these rules.

II. EPA's Evaluation and Action

A. How Is EPA Evaluating the Rules?

Generally, SIP rules must be enforceable (*see* section 110(a) of the CAA) and must not relax existing requirements (*see* sections 110(l) and 193 of the CAA).

CAA subpart 1 VOC rules must require Reasonably Available Control Measures (RACM), including Reasonably Available Control Technology (RACT), for each major VOC source in ozone nonattainment areas (*see* section 172(c)(1) of the CAA). The NSAQMD regulates a subpart 1 8-hr ozone nonattainment area in Western Nevada County (*see* 40 CFR part 81) and must fulfill the requirements of RACM/RACT in that area.

CAA subpart 2 VOC rules must require RACT for each significant source category covered by a Control Technique Guideline (CTG) document and for each major source in ozone nonattainment areas (*see* sections 182(a)(2) and (b)(2) of the CAA). The SJVUAPCD regulates a subpart 2 8-hr ozone nonattainment area which was classified under the 1-hr standard as an extreme nonattainment area (*see* 40 CFR part 81). Additionally, gasoline storage, transfer, and dispensing rules must fulfill the special requirements for gasoline vapor recovery in ozone nonattainment areas (*see* section 182(b)(3)(A) of the CAA) and special requirements for vehicle fleets (see section 202(a)(6) of the CAA).

Guidance and policy documents that we use to help evaluate specific enforceability and RACT requirements consistently include the following:

1. Portions of the proposed post-1987 ozone and carbon monoxide policy that concern RACT, 52 FR 45044 (November 24, 1987).

2. *Issues Relating to VOC Regulation Cutpoints, Deficiencies, and Deviations,* EPA (May 25, 1988) [The Bluebook].

3. *Guidance Document for Correcting Common VOC & Other Rule Deficiencies,* EPA Region 9 (August 21, 2001) [The Little Bluebook].

4. *Control of VOC from the Use of Cutback Asphalt,* EPA–450/2–77–037 (December 1977).

5. *SJVUAPCD 2004 Extreme Ozone Attainment Demonstration Plan.*

6. *SJVUAPCD 2007 Ozone Plan, http://www.arb.ca.gov/planning/sip/2007sip/sjv8hr/sjvozone.htm.*

7. *SJVUAPCD Final Staff Report, Proposed Amendments to Rule 4651* (September 20, 2007).

B. Do the Rules Meet the Evaluation Criteria?

We believe that NSAQMD Rule 227 and SJVUAPCD Rules 4621, 4622, and 4651 are consistent with the relevant policy and guidance regarding enforceability, RACT, and SIP relaxations. The TSDs have more information on our evaluation.

C. Public Comment and Final Action

Because EPA believes the submitted rules fulfill all relevant requirements, we are proposing to fully approve them as described in section 110(k)(3) of the Act. We will accept comments from the public on this proposal for the next 30 days. Unless we receive convincing new information during the comment period, we intend to publish a final approval action that will incorporate these rules into the Federally enforceable SIP.

III. Statutory and Executive Order Reviews

Under the Clean Air Act, the Administrator is required to approve a SIP submission that complies with the provisions of the Act and applicable Federal regulations. 42 U.S.C. 7410(k); 40 CFR 52.02(a). Thus, in reviewing SIP submissions, EPA's role is to approve State choices, provided that they meet the criteria of the Clean Air Act. Accordingly, this action merely approves State law as meeting Federal requirements and does not impose additional requirements beyond those imposed by State law. For that reason, this action:

- Is not a ''significant regulatory action'' subject to review by the Office of Management and Budget under Executive Order 12866 (58 FR 51735, October 4, 1993);
- Does not impose an information collection burden under the provisions of the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*);
- Is certified as not having a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*);
- Does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4);
- Does not have Federalism implications as specified in Executive

Order 13132 (64 FR 43255, August 10, 1999);

• Is not an economically significant regulatory action based on health or safety risks subject to Executive Order 13045 (62 FR 19885, April 23, 1997);

• Is not a significant regulatory action subject to Executive Order 13211 (66 FR 28355, May 22, 2001);

• Is not subject to requirements of Section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) because application of those requirements would be inconsistent with the Clean Air Act; and

• Does not provide EPA with the discretionary authority to address, as appropriate, disproportionate human health or environmental effects, using practicable and legally permissible methods, under Executive Order 12898 (59 FR 7629, February 16, 1994).

In addition, this rule does not have Tribal implications as specified by Executive Order 13175 (65 FR 67249, November 9, 2000), because the SIP is not approved to apply in Indian country located in the State, and EPA notes that it will not impose substantial direct costs on Tribal governments or preempt Tribal law.

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Incorporation by reference, Intergovernmental relations, Ozone, Reporting and recordkeeping requirements, Volatile organic compounds.

Dated: June 22, 2009.

Jane Diamond,

Acting Regional Administrator, Region IX.

[FR Doc. E9–16496 Filed 7–10–09; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA–R09–OAR–2009–0473; FRL–8929–6]

Revisions to the California State Implementation Plan, San Joaquin Valley Air Pollution Control District

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: EPA is proposing to approve revisions to the San Joaquin Valley Air Pollution Control District portion of the California State Implementation Plan (SIP). These revisions concern volatile organic compound (VOC) emissions from graphic arts printing operations, digital printing operations, adhesives, cleaning solvents, transfer of organic liquids, and facilities engaged in coating of wood products, flat paneling, paper, film, foil, and fabric. We are approving 4 local rules that regulate these emission sources under the Clean Air Act as amended in 1990 (CAA or the Act). We are taking comments on this proposal and plan to follow with a final action.

DATES: Any comments must arrive by August 12, 2009.

ADDRESSES: Submit comments, identified by docket number [EPA–R09–OAR–2009–0473], by one of the following methods:

1. *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the on-line instructions.

2. *E-mail: steckel.andrew@epa.gov.*

3. *Mail or delivery:* Andrew Steckel (Air–4), U.S. Environmental Protection Agency Region IX, 75 Hawthorne Street, San Francisco, CA 94105–3901.

Instructions: All comments will be included in the public docket without change and may be made available online at *http://www.regulations.gov*, including any personal information provided, unless the comment includes Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Information that you consider CBI or otherwise protected should be clearly identified as such and should not be submitted through *http://www.regulations.gov* or e-mail. *http://www.regulations.gov* is an ''anonymous access'' system, and EPA will not know your identity or contact information unless you provide it in the body of your comment. If you send e-mail directly to EPA, your e-mail address will be automatically captured and included as part of the public comment. If EPA cannot read your comment due to technical difficulties and cannot contact you for clarification, EPA may not be able to consider your comment.

Docket: The index to the docket for this action is available electronically at *http://www.regulations.gov* and in hard copy at EPA Region IX, 75 Hawthorne Street, San Francisco, California. While all documents in the docket are listed in the index, some information may be publicly available only at the hard copy location (*e.g.*, copyrighted material), and some may not be publicly available in either location (*e.g.*, CBI). To inspect the hard copy materials, please schedule an appointment during normal business hours with the contact listed in the **FOR FURTHER INFORMATION CONTACT** section.

FOR FURTHER INFORMATION CONTACT: Nicole Law, EPA Region IX, (415) 947–4126, *Law.Nicole@epa.gov*.

SUPPLEMENTARY INFORMATION: Throughout this document, ''we,'' ''us'' and ''our'' refer to EPA.

Table of Contents

I. The State's Submittal

A. What Rules Did the State Submit?

Table 1 lists the rules addressed by this proposal with the dates that they were adopted by the local air agency and submitted by the California Air Resources Board.

TABLE 1—SUBMITTED RULES

Local agency	Rule No.	Rule title	Adopted	Submitted
SJVAPCD	4606	Wood Products and Flat Wood Paneling Product Coating Operations	10/16/08	12/23/08
SJVAPCD	4607	Graphic Arts and Paper, Film, Foil, and Fabric Coatings	12/18/08	03/17/09
SJVAPCD	4624	Transfer of Organic Liquid	09/20/07	03/07/08
SJVAPCD	4653	Adhesives	12/20/07	03/07/08

On April 17, 2008 and April 20, 2009, EPA determined that these rule submittals met the completeness criteria in 40 CFR Part 51, Appendix V, which must be met before formal EPA review.

B. Are There Other Versions of These Rules?

There are no previous versions of Rule 4624 in the SIP. We approved earlier versions of Rules 4606 and 4607 into the SIP on June 26, 2002 (67 FR 42999). SJVAPCD adopted revisions to the SIP-approved version of Rule 4606 on September 20, 2007 and October 16, 2008 and CARB submitted them to us on March 7, 2008 and December 23, 2008. SJVAPCD adopted revisions to the SIP-approved version of Rule 4607 on September 20, 2007 and December 18, 2008 and CARB submitted them to us on March 7, 2008 and March 17, 2009. We approved an earlier version of Rule 4653 into the SIP on May 7, 2002 (57 FR 30591). SJVAPCD adopted revisions to the SIP-approved version of Rule 4653 on September 20, 2007 and CARB submitted it to us on March 7, 2008. While we are only acting on the most recently submitted version, we have reviewed materials provided with previous submittals.

C. What Is the Purpose of the Submitted Rules and Rule Revisions?

VOCs help produce ground-level ozone and smog, which harm human health and the environment. Section 110(a) of the CAA requires States to submit regulations that control VOC emissions. These rules control VOC emissions by limiting VOC content in coatings used for graphic arts operations, printing operations, wood products, flat paneling, paper, film, foil, and fabric. In addition, the rules limit VOCs by regulating adhesives, cleaning solvents, and transfer of organic liquids. EPA's technical support documents (TSDs) have more information about these rules.

II. EPA's Evaluation and Action

A. How Is EPA Evaluating the Rules?

Generally, SIP rules must be enforceable (*see* section 110(a) of the Act), must require Reasonably Available Control Technology (RACT) for each category of sources covered by a Control Techniques Guidelines (CTG) document as well as each major source in nonattainment areas (*see* sections 182(a)(2) and (b)(2)), and must not relax existing requirements (*see* sections 110(l) and 193). The SJVAPCD regulates an extreme (for the 1-hour NAAQS) and serious (for the 8-hour NAAQS) ozone nonattainment area (*see* 40 CFR part 81), so Rules 4606, 4607, 4626, and 4653 must fulfill RACT.

Guidance and policy documents that we use to evaluate enforceability and RACT requirements consistently include the following:

1. Portions of the proposed post-1987 ozone and carbon monoxide policy that concern RACT, 52 FR 45044, November 24, 1987.
2. ''Issues Relating to VOC Regulation Cutpoints, Deficiencies, and Deviations,'' EPA, May 25, 1988 (the Bluebook).
3. ''Guidance Document for Correcting Common VOC & Other Rule Deficiencies,'' EPA Region 9, August 21, 2001 (the Little Bluebook).
4. ''State Implementation Plans, General Preamble for the Implementation of Title I of the Clean Air Amendments of 1990,'' 57 FR 13498, April 16, 1992.
5. ''Preamble, Final Rule to Implement the 8-hour Ozone National Ambient Air Quality Standard'' 70 FR 71612; Nov. 29, 2005.
6. Letter from William T. Hartnett to Regional Air Division Directors, ''RACT Qs & As—Reasonable Available Control Technology (RACT) Questions and Answers,'' May 18, 2006.
7. ''Control of Volatile Organic Compound Emissions from Wood Furniture Manufacturing Operations,'' EPA–453/R–96–007, April 1996.
8. ''Control Techniques Guidelines for Flat Wood Paneling Coatings,'' EPA–453/R–06–004, September 2006.
9. ''Control Technique Guidelines for Control of VOCs from Existing Stationary Sources—Volume II: Surface Coating of Cans, Coils, Paper, Fabrics, Automobiles, and Light-Duty Trucks,'' EPA–450/2–77–008, May 1977.
10. ''Control Techniques Guidelines for Control of VOCs from Existing Stationary Sources—Volume VIII: Graphic Arts—Rotogravure and Flexography,'' EPA–450/2–78–033, December 1978.
11. ''Control Techniques Guidelines for Offset Lithographic Printing and Letterpress Printing,'' EPA–453/R–06–002, September 2006.
12. ''Control Techniques Guidelines for Flexible Package Printing,'' EPA–453/R–06–003, September 2006.
13. ''Control Techniques Guidelines for Paper, Film, and Foil Coatings,'' EPA–453/R–07–003, September 2007.
14. ''Control of Hydrocarbons from Tank Truck Gasoline Loading Terminals,'' EPA–450/2–77–026, October 1977.
15. ''Control Techniques Guidelines for Miscellaneous Industrial Adhesives,'' EPA–453/R–08–005, September 2008.
16. ''Determination of Reasonably Available Control Technology and Best Available Retrofit Control Technology for Adhesives and Sealants,'' CARB, December 1998.

B. Do the Rules Meet the Evaluation Criteria?

We believe these rules are consistent with the relevant requirements, policy, and guidance regarding enforceability, RACT, and SIP relaxations. The TSDs have more information on our evaluation.

C. EPA Recommendations To Further Improve the Rules

The TSDs describe additional rule revisions that do not affect EPA's current action but are recommended for the next time the local agency modifies the rules.

D. Public Comment and Final Action

Because EPA believes the submitted rules fulfill all relevant requirements, we are proposing to fully approve them as described in section 110(k)(3) of the Act. We will accept comments from the public on this proposal for the next 30 days. Unless we receive convincing new information during the comment period, we intend to publish a final approval action that will incorporate these rules into the Federally enforceable SIP.

III. Statutory and Executive Order Reviews

Under the Clean Air Act, the Administrator is required to approve a SIP submission that complies with the provisions of the Act and applicable Federal regulations. 42 U.S.C. 7410(k); 40 CFR 52.02(a). Thus, in reviewing SIP submissions, EPA's role is to approve State choices, provided that they meet the criteria of the Clean Air Act. Accordingly, this action merely approves State law as meeting Federal requirements and does not impose additional requirements beyond those imposed by State law. For that reason, this action:

- Is not a ''significant regulatory action'' subject to review by the Office of Management and Budget under Executive Order 12866 (58 FR 51735, October 4, 1993);
- Does not impose an information collection burden under the provisions of the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*);
- Is certified as not having a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*);
- Does not contain any unfunded mandate or significantly or uniquely

affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4);

• Does not have Federalism implications as specified in Executive Order 13132 (64 FR 43255, August 10, 1999);

• Is not an economically significant regulatory action based on health or safety risks subject to Executive Order 13045 (62 FR 19885, April 23, 1997);

• Is not a significant regulatory action subject to Executive Order 13211 (66 FR 28355, May 22, 2001);

• Is not subject to requirements of Section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) because application of those requirements would be inconsistent with the Clean Air Act; and

• Does not provide EPA with the discretionary authority to address, as appropriate, disproportionate human health or environmental effects, using practicable and legally permissible methods, under Executive Order 12898 (59 FR 7629, February 16, 1994).

In addition, this rule does not have Tribal implications as specified by Executive Order 13175 (65 FR 67249, November 9, 2000), because the SIP is not approved to apply in Indian country located in the State, and EPA notes that it will not impose substantial direct costs on Tribal governments or preempt Tribal law.

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Intergovernmental relations, Ozone, Reporting and recordkeeping requirements, Volatile organic compounds.

Authority: 42 U.S.C. 7401 *et seq.*

Dated: June 26, 2009.

Jane Diamond,

Acting Regional Administrator, Region IX.

[FR Doc. E9–16490 Filed 7–10–09; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

42 CFR Part 73

Possession, Use, and Transfer of Select Agents and Toxins; Proposed Addition of SARS-Associated Coronavirus (SARS–CoV)

AGENCY: Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (HHS).

ACTION: Notice of proposed rulemaking.

SUMMARY: The biological agents and toxins listed in § 73.3 of Title 42 of the Code of Federal Regulations have been determined by the Secretary of the U.S. Department of Health and Human Services (HHS Secretary) to have the potential to pose a severe threat to public health and safety. We are now proposing to add SARS-associated coronavirus (SARS–CoV) to the list of HHS select agents and toxins. We are proposing this action because (1) SARS–CoV can cause significant mortality, especially in the elderly; (2) the virus has the capability of easily being transmitted from human to human; (3) there is currently no vaccine or antiviral approved for the prevention or treatment of infections caused by the SARS–CoV virus; and (4) it has been documented that the virus may persist in the environment.

DATES: Written comments must be received on or before September 11, 2009. Comments received after September 11, 2009 will be considered to the extent practicable.

ADDRESSES: Comments on the proposed addition of SARS–CoV to the list of select agents and toxins should be marked ''SARS–CoV'' and mailed to: Centers for Disease Control and Prevention, Division of Select Agents and Toxins, 1600 Clifton Road, MS A–46, Atlanta, GA 30333. Comments may be e-mailed to: *SAPcomments@cdc.gov*.

FOR FURTHER INFORMATION CONTACT: Robbin Weyant, Director, Division of Select Agents and Toxins, Centers for Disease Control and Prevention, 1600 Clifton Road, MS A–46, Atlanta, GA 30333. Telephone: (404) 718–2000.

SUPPLEMENTARY INFORMATION: The Public Health Security and Bioterrorism Preparedness and Response Act of 2002, Subtitle A of Public Law 107–188 (42 U.S.C. 262a) (the Bioterrorism Act), requires the HHS Secretary to establish by regulation a list of each biological agent and each toxin that has the potential to pose a severe threat to public health and safety. In determining whether to include an agent or toxin on the list, the HHS Secretary considers the effect on human health of exposure to an agent or toxin; the degree of contagiousness of an agent and the methods by which an agent or toxin is transferred to humans; the availability and effectiveness of pharmacotherapies and immunizations to treat and prevent illnesses resulting from an agent or toxin; the potential for an agent or toxin to be used as a biological weapon; and the needs of children and other vulnerable populations.

SARS-associated coronavirus (SARS–CoV) causes a viral respiratory illness, severe acute respiratory syndrome (SARS), which was first reported in Asia in February 2003. According to the World Health Organization (WHO)[i], a total of 8,098 people worldwide became sick with SARS during the 2003 outbreak, resulting in 774 deaths. SARS–CoV is thought to be transmitted most readily by respiratory droplets (droplet spread) produced when an infected person coughs or sneezes. The virus also can spread when a person touches a surface or object contaminated with infectious droplets and then touches his or her mouth, nose, or eye(s). In addition, it is possible that SARS–CoV might be spread more broadly through the air (airborne spread) or by other ways that are not now known. There is currently no known SARS transmission anywhere in the world. The last known human cases of SARS–CoV infection as reported by the World Health Organization occurred in China in April 2004 in an outbreak resulting from laboratory-acquired infections.

After consulting with subject matter experts from the CDC, the National Institutes of Health (NIH), the Food and Drug Administration (FDA), the United States Department of Agriculture (USDA)/Animal and Plant Health Inspection Service (APHIS), USDA/Agricultural Research Service (ARS), USDA/CVB (Center for Veterinary Biologics), and the Department of Defense (DOD)/United States Army Medical Research Institute for Infectious Diseases (USAMRIID) and conducting a review of relevant published studies, we are proposing that SARS–CoV should be added to the list of HHS select agents and toxins because:

• The virus causes significant mortality, especially in the elderly.[ii iii]

• The virus has the capability of easily being transmitted from human-to-human.[iv]

• There is currently no method to treat infections caused by the virus.[v]

• It has been demonstrated that the virus may persist in the environment.

We will consider comments that are received within 60 days of publication of this notice in the **Federal Register**. After the comment period closes, we will publish another document in the **Federal Register**. The document will include a discussion of any comments we receive and any changes to the list of HHS select agents and toxins.

Compliance Dates

We recognize that there may be some individuals and/or entities that are not currently registered under either the HHS or USDA Select Agent Programs, but that do possess SARS–CoV and would therefore be required to register

with HHS should this proposed amendment be finalized.

Accordingly, as a result of this rule, an individual or entity that currently possesses SARS–CoV, if they are not already a registered entity, would have to either transfer the SARS–CoV to an individual or entity that was registered to possess SARS–CoV or become a registered individual or entity themselves. We recognize that an individual or entity that chooses to become registered for possession of SARS–CoV will need time to come into full compliance with the requirements of the regulations, including the granting of individual access through the security risk assessment process. To minimize the disruption of research, educational projects (*e.g.*, teaching demonstrations), or other important activities involving SARS–CoV that might be underway as of the effective date of these proposed regulations, we are also proposing to provide that any unregistered individual or entity possessing SARS–CoV as of the effective date (current unregistered possessors) will be afforded time to reach full compliance with the select agent regulations (42 CFR part 73). Therefore, we are proposing that any current possessor of SARS–CoV must be fully registered and in full compliance with all provisions of the Select Agent Regulations not later than 180 days after the effective date of a final rule.

The Responsible Official for currently registered individuals or entities that possess SARS–CoV would be required to provide notice in the form of an amendment to their registration to HHS or USDA regarding their possession of SARS–CoV not later than 15 days after the effective day of this proposed amendment.

Regulatory Analyses

Paperwork Reduction Act

This proposed rule contains no new information collection or recordkeeping requirements under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

Executive Order 12866 and Regulatory Flexibility Act

This rule will add SARS–CoV to the HHS select agent list. The purpose of the regulation of select agents and toxins is to reduce the potential for these agents and toxins to pose a severe threat to public health and safety by establishing Federal requirements for biosafety, security, training, and personnel surety. Should any select agent or toxin be intentionally or accidentally introduced into the population of the United States, the consequences could be significant. The individuals and entities most likely to be affected by this proposed rule are those individuals at laboratories and other institutions conducting research and related activities that involve the use of SARS–CoV.

Based on CDC data, there are 138 entities that currently possess SARS–CoV. Of those 138 entities, 73 entities are registered with the select agent program of either HHS or USDA. The majority of the non-registered entities are commercial entities.

Costs. Our estimate of the long-term cost of implementing the select agent regulations is based on the actual costs incurred by registering entities implementing the interim final rule that became fully applicable on November 12, 2003. Additionally, before the interim final rule was issued in December 2002, CDC contacted a number of entities to assess existing practices. Because many of the laboratories that will register under this proposal are already substantially in compliance with the required practices, the costs of the rule should be limited.

Benefits. The benefits to public health and safety from implementation of the rule are clear, although difficult to quantify. The benefits of the final rule will be the decreased risk of accidental or intentional release of a select agent derived from the establishment of Federal requirements for biosafety, security, training, and personnel surety. The cost of such an event in human life could be very high. The release of a select agent or toxin could result in a public health emergency requiring an extensive and expensive response. This effort could include extensive public health measures, such as quarantine, preventative treatment and health testing for large numbers of potentially exposed persons, and extensive decontamination. Substantial costs could be incurred by hospitals and other medical facilities and institutions of government at all levels. A release, or widespread fear of one, also would create significant secondary effects. It could disrupt business, transportation, and many other aspects of normal behavior, on both a short-term and potentially a long-term basis.

The impacts resulting from the October 2001 anthrax attacks provide an example of the costs that a release could incur. The anthrax attacks caused five fatalities and 17 illnesses, disrupted business and government activities, and caused widespread apprehension and changes in behavior. Costs included more than $23 million to decontaminate one Senate office building; approximately $2 billion in revenues lost to the postal service, and as much as $3 billion in additional costs to the postal service for cleanup of contamination and procurement of mail sanitizing equipment.[1] Substantial costs due to lost productivity throughout the economy and from ongoing costs of the investigations into the incident are additional impacts.

Implementation of this rule will continue to provide a means for the registration of those who possess select agents; ensure that their transfer, storage, and use can be tracked; provide for the screening of personnel with access to such agents; and require that entities in possession of such agents develop and implement effective means of biosafety and physical security. The benefit of these provisions is a reduced likelihood of either an accidental or intentional release of select agents or the consequent avoidance of costs associated with such a release.

Impacts resulting from the costs of the rule should not be significant. The annualized cost on small entities would not exceed one percent of sales or revenue stream and the initial cost would not exceed three percent of sales or revenue stream, according to the economic analysis, ''Regulatory Impact Analysis, 42 CFR part 73, Possession, Use, and Transfer of Select Biological Agents and Toxins Final Rule.'' To request a copy of this report, send an e-mail to *SAPcomments@cdc.gov*. The HHS Secretary hereby certifies that the final rule will not have a significant economic impact on a substantial number of small entities.

Insert on Small Entity Impact

The Regulatory Flexibility Act (RFA) of 1980, as amended by the Small Business Regulatory Enforcement Fairness Act of 1996, requires agencies to prepare an initial regulatory flexibility analysis for any rule subject to notice and comment rulemaking unless the agency is able to certify that the rule will not have a significant economic impact on a substantial number of small entities.

HHS guidance on the treatment of small entities suggests that a ''substantial number'' should be considered to mean 5 percent or more of the affected small entities within an identified industry. The U.S. Small Business Administration (SBA) has established size standards for all for-profit industries based on either the

[1] Regulatory Impact Analysis for 42 CFR Part 73: Possession, Use, and Transfer of Select Biological Agents and Toxins Final Rule. Centers for Disease Control and Prevention, Department of Health and Human Services. February 3, 2005.

number of employees or annual revenue, depending on the North American Industry Classification System (NAICS) classification. Most affected entities would be considered part of NAICS code 5417102 Research and Development in Life Sciences. Per the SBA's *Table of Small Business Size Standards*, the Research and Development entities in NAICS code 5417102 are considered small if they have fewer than 500 employees.[2] According to the Economic Census, there are 4,674 life sciences research and development establishments that are categorized as ''small'' using this standard.[3] Based on CDC data, there are 138 entities that are known to currently possess SARS–Co–V, and even if all 138 entities were considered small, less than 3 percent of the small facilities in NAICS code 5417102 would be affected by the rule.

Furthermore, the HHS guidance defines a ''significant economic impact'' as an average annual impact of 3 to 5 percent or more of total costs or revenues. The 65 entities that are not registered with the select agent program must comply with the select agent regulations, including becoming registered and ensuring adequate biosafety and containment measures, physical security, training, and recordkeeping. The average cost for a facility to register with CDC and otherwise comply with 42 CFR part 73 is estimated to range from $15,300 to $170,000 (70 FR 13315, March 18, 2005). The 73 entities that are already registered because they possess other listed select agents or toxins would need to amend their registrations, but they are likely to already have adequate physical security, training programs, and recordkeeping systems to enable them to safely and securely possess and use SARS–CoV. The average revenue for the small establishments in NAICS code 5417102 is about $3,493,000, so the average annual impact for facilities to comply with the rule would range from less than 1 percent to less than 5 percent.

Therefore, the HHS Secretary has certified that the final rule will not have a significant economic impact on a substantial number of small entities.

[2] U.S. Small Business Administration. Table of Small Business Size Standards Matched to North American Industry Classification System Codes. August 22, 2008. Available at: *http://www.sba.gov/idc/groups/public/documents/sba_homepage/serv_sstd_tablepdf.pdf.*

[3] *http://factfinder.census.gov/servlet/IBQTable?_bm=y&-geo_id=&-fds_name=EC0200A1&-_skip=800&-ds_name=EC0254SSSZ5&-_lang=en.*

Executive Order 12988

This Notice of Proposed Rulemaking has been reviewed under Executive Order 12988, Civil Justice Reform. This rule: (1) Would preempt all State and local laws and regulations that are inconsistent with this rule; (2) would have no retroactive effect; and (3) would not require administrative proceedings before parties may file suit in court challenging this rule.

List of Subjects in 42 CFR Part 73

Biologics, Incorporation by reference, Packaging and containers, Penalties, Reporting and recordkeeping requirements, Transportation.

Dated: June 9, 2009.

Kathleen Sebelius,

Secretary.

For the reasons stated in the preamble, we are proposing to amend 42 CFR part 73 as follows:

PART 73—SELECT AGENTS AND TOXINS

1. The authority citation for part 73 continues to read as follows:

Authority: 42 U.S.C. 262a; sections 201–204, 221 and 231 of Title II of Public Law 107–188, 116 Stat. 637 (42 U.S.C. 262a).

2. Amend paragraph (b) of § 73.3 by adding the following entry in alphabetical order to read as follows:

§ 73.3 HHS select agents and toxins.

* * * * *

(b) * * *

SARS-associated coronavirus (SARS–CoV)

* * * * *

[FR Doc. E9–16536 Filed 7–10–09; 8:45 am]

BILLING CODE 4163–18–P

[i] World Health Organization, *SARS: How a global epidemic was stopped.* 2006.

[ii] Poutanen SM, Low DE, Henry B, *et al.* Identification of severe acute respiratory syndrome in Canada. N Engl J Med 2003; 348:1995–2005.

[iii] Lee N, Hui D, Wu A, *et al.* A major outbreak of severe acute respiratory syndrome in Hong Kong. N Engl J Med 2003; 348:1986–1994.

[iv] Ksiazek TG, Erdman D, Goldsmith CS, *et al.* A novel coronavirus associated with severe acute respiratory syndrome. N Engl J Med 2003; 348:1953–1966.

[v] Holmes KV. SARS coronavirus: a new challenge for prevention and therapy. J Clin Invest 2003; 111:1605–9.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 410, 411, 414, 415, and 485

[CMS–1413–CN]

RIN 0938–AP40

Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010; Correction

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Correction of proposed rule.

SUMMARY: This document corrects a technical error in the proposed rule entitled ''Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010'' which appears elsewhere in this **Federal Register**.

FOR FURTHER INFORMATION CONTACT: Diane Milstead, (410) 786–3355.

SUPPLEMENTARY INFORMATION:

I. Background

In FR Doc. E9–15835 of July 13, 2009, there was a technical error that is identified and corrected in the Correction of Errors section below.

II. Summary of Errors

In section V., Regulatory Impact Analysis, of the preamble of the proposed rule entitled ''Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010'' that is published elsewhere in this **Federal Register**, we inadvertently omitted language regarding the impact of the proposed Physician Fee Schedule Update for CY 2010.

III. Correction of Errors

In FR Doc. E9–15835 of July 13, 2009, to make a correction to section V. of the preamble, the Regulatory Impact Analysis, prior to the section labeled ''U. Alternatives Considered,'' the following language should be inserted:

''*L. Physician Fee Schedule Update for CY 2010* In section II.P. of the proposed rule, we describe our proposal to remove physician-administered drugs from the definition of physicians' services for purposes of calculating allowed and actual expenditures for all years since the 1996/1997 base year, and for purposes of calculating the SGR for 2010 and all subsequent years. While this proposal would not change the

projected −21.5 percent physician payment rate update for services furnished on or after January 1, 2010, this change would reduce the discrepancy between actual and target expenditures. Based on the President's budget, we estimate this proposal would cost $45.4 billion from 2010 to 2014. Projected updates would increase over this same period from between −6.3 and −5.4 percent to between −3.1 and +1.4 percent respectively.''

Authority: Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program.

Dated: July 8, 2009.

Ashley Files Flory,

Acting Executive Secretary to the Department.

[FR Doc. E9–16507 Filed 7–8–09; 4:15 pm]

BILLING CODE 4120–01–P

Notices

Federal Register
Vol. 74, No. 132
Monday, July 13, 2009

This section of the FEDERAL REGISTER contains documents other than rules or proposed rules that are applicable to the public. Notices of hearings and investigations, committee meetings, agency decisions and rulings, delegations of authority, filing of petitions and applications and agency statements of organization and functions are examples of documents appearing in this section.

DEPARTMENT OF AGRICULTURE

Farm Service Agency

Information Collection Request, Servicing Minor Program Loans

AGENCY: Farm Service Agency, USDA.

ACTION: Notice and request for comments.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, FSA is requesting comments from all interested individuals and organizations on a currently approved information collection to support the FSA Farm Loan Programs (FLP).

DATES: We will consider comments that we receive by September 11, 2009.

ADDRESSES: We invite you to submit comments on this notice. In your comments, include date, volume, and page number of this issue of **Federal Register**. You may submit comments by any of the following methods:

- *Mail:* Mel Thompson, USDA, Farm Service Agency, Loan Servicing and Property Management Division, 1250 Maryland Avenue, SW., Suite 500, Washington, DC 20024;
- *E-mail: mel.thompson@wdc.usda.gov*;
- *Fax:* 720–5804.
- *Hand Delivery or Courier:* Deliver comments to Farm Service Agency, Loan Servicing and Property Management Division, 1280 Maryland Avenue, SW., Suite 500, Washington, DC 20024.

You may also send comments to the Desk Officer for Agriculture, Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, DC 20503.

FOR FURTHER INFORMATION CONTACT: Mel Thompson, Senior Loan Officer, (202) 720–7862.

SUPPLEMENTARY INFORMATION:

Title: Servicing Minor Program Loans.
OMB Control Number: 0560–0230.
Expiration Date: January 31, 2010.
Type of Request: Extension.

Abstract: Section 331 of the Consolidated Farm and Rural Development Act, 7 U.S.C. 1981, (''CONACT'') in part, authorizes the Secretary of Agriculture to modify, subordinate and release terms of security instruments, leases, contracts, and agreements entered into by FSA. That section also authorizes transfers of security property, as the Secretary deems necessary, to carry out the purpose of the loan or protect the Government's financial interest. Section 335 of the CONACT (7 U.S.C. 1985), provides servicing authority for real estate security; operation or lease of realty; disposition of property; conveyance of real property interest of the United States; easements; and condemnations. The information collection relates to a program benefit recipient or loan borrower requesting action on security they own, which was purchased with FSA loan funds, improved with FSA loan funds or has otherwise been mortgaged to FSA to secure a Government loan. The information collected is primarily financial data not already on file, such as borrower asset values, current financial information and public use and employment data.

Estimate of Annual Burden: Public reporting burden for this collection of information is estimated to average .52 hours per response.

Respondents: Individuals, associations, partnerships, or corporations.

Estimated Number of Respondents: 226.

Estimated Number of Responses per Respondent: 1.

Estimated Total Annual Burden on Respondents: 117.5 hours.

We are requesting comments on all aspects of this information collection including the follow to help us to:

(1) Evaluate whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

(2) Evaluate the accuracy of the agency's estimate of burden including the validity of the methodology and assumptions used;

(3) Enhance the quality, utility and clarity of the information to be collected;

(4) Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology.

All responses to this Notice will be summarized and included in the information collection request for Office of Management and Budget approval. All comments will also become a matter of public record.

Signed in Washington, DC, on July 6, 2009.

Douglas J. Caruso,

Administrator, Farm Service Agency.

[FR Doc. E9–16403 Filed 7–10–09; 8:45 am]

BILLING CODE 3410–05–P

DEPARTMENT OF AGRICULTURE

Natural Resources Conservation Service

Notice of Proposed Change to Section IV of the Virginia State Technical Guide

AGENCY: Natural Resources Conservation Service (NRCS), U.S. Department of Agriculture.

ACTION: Notice of availability of proposed changes in the Virginia NRCS State Technical Guide for review and comment.

SUMMARY: It has been determined by the NRCS State Conservationist for Virginia that changes must be made in the NRCS State Technical Guide specifically in practice standards: #314, Brush Management; #382, Fence; #646, Shallow Water Development and Management; #658, Wetland Creation; #659, Wetland Enhancement; #657, Wetland Restoration; and #644, Wetland Wildlife Habitat Management. These practices will be used to plan and install conservation practices on cropland, pastureland, woodland, and wildlife land.

DATES: Comments will be received for a 30-day period commencing with this date of publication.

FOR FURTHER INFORMATION CONTACT: John A. Bricker, State Conservationist, Natural Resources Conservation Service (NRCS), 1606 Santa Rosa Road, Suite 209, Richmond, Virginia 23229–5014; Telephone number (804) 287–1691; Fax number (804) 287–1737. Copies of the practice standards will be made available upon written request to the address shown above or on the Virginia

NRCS Web site: *http://www.va.nrcs.usda.gov/technical/draftstandards.html.*

SUPPLEMENTARY INFORMATION: Section 343 of the Federal Agriculture Improvement and Reform Act of 1996 states that revisions made after enactment of the law to NRCS State technical guides used to carry out highly erodible land and wetland provisions of the law shall be made available for public review and comment. For the next 30 days, the NRCS in Virginia will receive comments relative to the proposed changes. Following that period, a determination will be made by the NRCS in Virginia regarding disposition of those comments and a final determination of change will be made to the subject standards.

Dated: July 1, 2009.

W. Ray Dorsett,

Assistant State Conservationist for Operations, Natural Resources Conservation Service, Richmond, Virginia.

[FR Doc. E9–16500 Filed 7–10–09; 8:45 am]

BILLING CODE 3410–16–P

DEPARTMENT OF COMMERCE

International Trade Administration

A–201–836

Light–Walled Rectangular Pipe and Tube from Mexico; Extension of Time Limit for Final Results of Antidumping Duty Changed Circumstances Review

AGENCY: Import Administration, International Trade Administration, Department of Commerce.

SUMMARY: The Department of Commerce (the Department) finds that it is not practicable to complete the final results of this changed circumstances review within the original time frame as it would be impossible to consider the parties comments and to complete the final results of this changed circumstances review within the original time frame. Accordingly, the Department is extending the time limit for completion of the final results of this changed circumstances review by 31 days to August 17, 2009.

FOR FURTHER INFORMATION CONTACT: John Drury or Brian Davis, AD/CVD Operations, Office 7, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue NW, Washington, DC 20230; telephone: (202) 482–0195 or (202) 482–7924, respectively.

SUPPLEMENTARY INFORMATION:

Background

On October 27, 2008, the Department published its notice of initiation of antidumping duty changed circumstances review. *See Notice of Initiation of Antidumping Duty Changed Circumstances Review: Light–Walled Rectangular Pipe and Tube from Mexico*, 73 FR 63686 (October 27, 2008) (*Notice of Initiation*). On June 18, 2009, the Department preliminarily determined that Ternium is the successor–in-interest to Hylsa and should be treated as such for antidumping duty cash deposit purposes. *See Notice of Preliminary Results of Antidumping Duty Changed Circumstances Review: Light–Walled Rectangular Pipe and Tube from Mexico*, 74 FR 28887 (June 18, 2009) (*Preliminary Results*).

Extension of Time Limits for Preliminary Results

The antidumping statute does not provide for a specific time limit for completing a changed circumstances review. However, under 19 CFR 351.216(e), the Department will issue the final results of a changed circumstances review within 270 days after the date on which the Department initiates the changed circumstances review. Currently, the final results of the antidumping duty changed circumstances review, which cover Hylsa, a producer/exporter of light–walled rectangular pipe and tube from Mexico, and its successor Ternium, are due by July 17, 2009.

In the *Preliminary Results*, we stated that interested parties could request a hearing and submit case briefs to the Department no later than 30 days after the publication of the *Preliminary Results*, and submit rebuttal briefs, limited to the issues raised in those case briefs, five days subsequent to the case briefs' due date. As comments are currently due no later than July 20, 2009,[1] and the final results are currently due July 17, 2009, it would be impossible to consider the parties comments and to complete the final results of this changed circumstances review within the original time frame. Accordingly, pursuant to 19 CFR 351.302(b), the Department is extending the time limit for completion of the final results of this changed circumstances review by 31 days to August 17, 2009. *See, e.g., Certain Pasta from Italy: Notice of Extension of Final Results of Antidumping Duty Changed Circumstances Review*, 73 FR 46871 (August 12, 2008) and *Polyethylene Terephthalate Film Sheet and Strip from the Republic of Korea: Extension of Time Limit for Final Results of Changed Circumstances Review*, 73 FR 6931 (February 6, 2008).

This notice is issued and published in accordance with sections 751(b) and 777(i) of the Tariff Act of 1930, as amended.

Dated: July 8, 2009.

John M. Andersen,

Acting Deputy Assistant Secretaryfor Antidumping and Countervailing Duty Operations.

[FR Doc. E9–16648 Filed 7–10–09; 8:45 am]

BILLING CODE 3510–DS–S

[1] Day 30 falls on a Saturday. Therefore, interested parties have until Monday, July 20, 2009, to request a hearing and submit case briefs to the Department.

DEPARTMENT OF COMMERCE

International Trade Administration

[A–570–827]

Certain Cased Pencils from the People's Republic of China: Final Results and Partial Rescission of Antidumping Duty Administrative Review

AGENCY: Import Administration, International Trade Administration, Department of Commerce.

SUMMARY: On January 7, 2009, the Department of Commerce (the ''Department'') published the preliminary results of the administrative review of the antidumping duty order on certain cased pencils from the People's Republic of China, covering the period December 1, 2006, through November 30, 2007. *See Certain Cased Pencils from the People's Republic of China; Preliminary Results and Partial Rescission of Antidumping Duty Administrative Review*, 74 FR 673 (January 7, 2009) (''*Preliminary Results*''). We gave the interested parties an opportunity to comment on the *Preliminary Results*. After reviewing the interested parties' comments, we made changes to our calculations for the final results of the review. The final dumping margin for this review is listed in the ''Final Results of the Review'' section below.

EFFECTIVE DATE: July 13, 2009.

FOR FURTHER INFORMATION CONTACT: David Layton or Alexander Montoro, AD/CVD Operations, Office 1, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue, N.W., Washington, DC 20230; telephone (202) 482–0371 or (202) 482–0238, respectively.

SUPPLEMENTARY INFORMATION:

Background

The Department published the *Preliminary Results* on January 7, 2009. On January 12, 2009, the Department sent supplemental questionnaires to mandatory respondents China First Pencil Co., Ltd. (''China First''), Shanghai Three Star Stationery Industry Corp. (''Three Star''), and Shandong Rongxin Import & Export Co., Ltd. (''Rongxin'') (collectively, ''the respondents''), and received responses from China First and Three Star on February 2, 2009, a response from Rongxin on January 29, 2009, and an addendum to Rongxin's response on February 18, 2009. The Department sent a supplemental questionnaire to Three Star on February 20, 2009, and received a response on February 23, 2009. China First, Three Star, and the petitioners, Sanford L.P., Musgrave Pencil Company, RoseMoon Inc., and General Pencil Company (collectively, ''the petitioners''), submitted comments on Three Star's February 23, 2009, supplemental response on February 25, 2009. Additional supplemental questionnaires were sent to Rongxin, China First, and Three Star on March 25, and April 21, 2009, respectively, and responses were received from Rongxin on April 3, 2009, and from China First and Three Star on April 28, 2009.

China First, Three Star, and the petitioners, submitted surrogate value comments on February 10, 2009. On February 9 and 10, 2009, the petitioners submitted factual information, and China First and Three Star issued a rebuttal to that factual information on February 12, 2009.

From February 16 through February 28, 2009, we conducted verification of the questionnaire responses submitted by China First and Three Star. The Department released its verification reports for China First and Three Star to interested parties on May 22, 2009.

As noted in the *Preliminary Results*, five respondents subject to this review were not selected as mandatory respondents.[1] We issued separate rate applications and certifications to all five of these companies. We are rescinding one of these respondents, Dixon, as requested, on the basis that it had no shipments in the POR, as discussed below. SFTC filed its separate rate certification on July 24, 2008. In our analysis of the information on the record regarding SFTC, we found no information indicating the existence of government control of SFTC's export activities. *See* SFTC's submission of July 24, 2008. Consequently, we determine that SFTC has met the criteria for the application of a separate rate. The remaining three non–mandatory respondents did not submit either a separate rates certification or application. One of these three companies, Tianjin, qualified for a separate rate in an earlier administrative review. *See Certain Cased Pencils from the People's Republic of China; Final Results and Partial Rescission of Antidumping Duty Administrative Review*, 68 FR 43082, 43084 (July 21, 2003). However, because Tianjin did not submit a separate rate certification in the instant review, it will now be treated as part of the PRC–wide entity. Consequently, Anhui, Guangdong, and Tianjin have not satisfied the criteria for separate rates for the POR and are considered as being part of the PRC–wide entity.

The petitioners and the respondents submitted case briefs on June 2, 2009 and rebuttal briefs on June 8, 2009. None of the parties requested a hearing.

Final Partial Rescission

On July 3, 2008, Beijing Dixon Stationery Company Ltd. (''Dixon'') requested that the Department rescind the administrative review with respect to Dixon and certified that it had no exports, sales or entries of subject merchandise to the United States during the Period of Review (''POR''). We reviewed U.S. Customs and Border Protection (''CBP'') import data and found no evidence that Dixon had any shipments of subject merchandise during the POR. In addition, on July 17, 2008, we made a ''No Shipments Inquiry'' to CBP to confirm that there were no exports of subject merchandise by Dixon during the POR. We asked CBP to notify us within ten days if CBP ''has contrary information and is suspending liquidation'' of subject merchandise exported by Dixon. CBP did not reply with contrary information. *See* Memorandum from Alexander Montoro to the File, entitled ''Intent to Rescind in Part the Antidumping Duty Administrative Review on Certain Cased Pencils from the People's Republic of China,'' August 7, 2008 (''Intent to Rescind Memo''). The Department provided interested parties in this review until August 14, 2008, to submit comments on the Intent to Rescind Memo. No interested party submitted any comments. Accordingly, we are rescinding this review with respect to Dixon.

Scope of the Order

Imports covered by the order are shipments of certain cased pencils of any shape or dimension (except as described below) which are writing and/or drawing instruments that feature cores of graphite or other materials, encased in wood and/or man–made materials, whether or not decorated and whether or not tipped (*e.g.*, with erasers, etc.) in any fashion, and either sharpened or unsharpened. The pencils subject to the order are currently classifiable under subheading 9609.10.00 of the Harmonized Tariff Schedule of the United States (''HTSUS''). Specifically excluded from the scope of the order are mechanical pencils, cosmetic pencils, pens, non–cased crayons (wax), pastels, charcoals, chalks, and pencils produced under U.S. patent number 6,217,242, from paper infused with scents by the means covered in the above–referenced patent, thereby having odors distinct from those that may emanate from pencils lacking the scent infusion. Also excluded from the scope of the order are pencils with all of the following physical characteristics: (1) length: 13.5 or more inches; (2) sheath diameter: not less than one–and-one quarter inches at any point (before sharpening); and (3) core length: not more than 15 percent of the length of the pencil.

In addition, pencils with all of the following physical characteristics are excluded from the scope of the order: novelty jumbo pencils that are octagonal in shape, approximately ten inches long, one inch in diameter before sharpening, and three–and-one eighth inches in circumference, composed of turned wood encasing one–and-one half inches of sharpened lead on one end and a rubber eraser on the other end.

Although the HTSUS subheading is provided for convenience and customs purposes, the written description of the scope of the order is dispositive.

Analysis of Comments Received

All issues raised in the case briefs are addressed in the ''Issues and Decision Memorandum for the 2006–2007 Administrative Review of Certain Cased Pencils from the People's Republic of China'' (''Issues and Decision Memorandum''), which is dated concurrently with and hereby adopted by this notice. A list of the issues which parties raised and to which we responded in the Issues and Decision Memorandum is attached to this notice as an Appendix. The Issues and Decision Memorandum is a public document which is on file in the Central Records Unit in room 1117 in the main

[1] Beijing Dixon Stationery Company Ltd. (''Dixon''), Oriental International Holding Shanghai Foreign Trade Co., Ltd. (''SFTC''), Guangdong Provincial Stationery & Sporting Goods Import & Export Corporation (''Guangdong''), Tianjin Custom Wood Processing Co., Ltd. (''Tianjin''), and Anhui Import & Export Co., Ltd. (''Anhui'').

Department building, and is accessible on the web at http://www.ia.ita.doc.gov/frn. The paper copy and electronic version of the memorandum are identical in content.

Changes Since the Preliminary Results

Based on our analysis of the comments received, we made the following changes in calculating dumping margins: (1) we adjusted the surrogate value for slats to reflect wood loss in producing slats from lumber; (2) we corrected the World Trade Atlas (''WTA'') data, which we used as surrogate values, for certain exclusions and errors made in the *Preliminary Results*; (3) we made corrections to certain clerical errors. In addition, we have calculated separate antidumping margins for China First and Three Star. *See* Comment 1 of the Issues and Decision Memorandum. For further details, *see* ''Analysis for the Final Results of Antidumping Duty Administrative Review of Certain Cased Pencils from the People's Republic of China: Shanghai Three Star Stationery Industry Co., Ltd.,'' ''Analysis for the Final Results of Antidumping Duty Administrative Review of Certain Cased Pencils from the People's Republic of China: China First Pencil Co., Ltd.,'' ''Analysis for the Final Results of Antidumping Duty Administrative Review of Certain Cased Pencils from the People's Republic of China: Shandong Rongxin Import & Export Co.'' and ''2006–2007 Antidumping Duty Administrative Review of Certain Cased Pencils from the People's Republic of China: Factor Valuation for the Final Results'' memoranda, all dated July 6, 2009.

Final Results of the Review

We determine that the following percentage weighted–average dumping margin exists for the period December 1, 2006, through November 30, 2007:

Manufacturer/exporter	Margin (percent)
China First Pencil Company, Ltd. (which includes its affiliates China First Pencil Fang Zheng Co., Shanghai First Writing Instrument Co., Ltd., and Shanghai Great Wall Pencil Co., Ltd.)	26.32
Shanghai Three Star Stationery Industry Corp.	60.91
Shandong Rongxin Import & Export Co., Ltd.	11.48
Orient International Holding Shanghai Foreign Trade Co., Ltd.	32.90
PRC–wide Entity[2]	114.90

[2]The PRC-wide entity includes Anhui Import Export Co., Ltd. (''Anhui''), Guangdong Provincial Stationery and Sporting Goods Import Export Corporation (''Guangdong''), and Tianjin Custom Wood Processing Co., Ltd. (''Tianjin''). A review was requested for these three companies.

As stated above in the ''Background'' section of this notice, SFTC qualifies for a separate rate in this review. Moreover as stated above in the ''Background'' section of this notice, we did not select SFTC as a mandatory respondent in this review. Therefore, SFTC is being assigned a dumping margin based on the calculated margins of mandatory respondents which are not de minimis or based on adverse facts available, in accordance with Department practice. Accordingly, we have assigned SFTC the simple–average of the dumping margins assigned to the China First, Three Star, and Rongxin.

Assessment Rates

The Department has determined, and CBP shall assess, antidumping duties on all appropriate entries. The Department intends to issue assessment instructions to CBP 15 days after the date of publication of the final results of review.

For China First, Three Star, and Rongxin, we calculated customer–specific antidumping duty assessment amounts for subject merchandise based on the ratio of the total amount of antidumping duties calculated for the examined sales of subject merchandise to the total quantity of subject merchandise sold in these transactions. We calculated these per unit assessment amounts in this fashion, as opposed to calculating import–specific ad valorem rates in accordance with 19 CFR 351.212 (b)(1), because the entered values and importers of record for China First's, Three Star's, and Rongxin's reported U.S. sales are not on the record. Where the customer–specific assessment rate is above *de minimis*, we will instruct CBP to assess the customer–specific rate uniformly on the entered customs value of all POR entries of subject merchandise sold to the customer. To determine whether the per–unit duty assessment rates were *de minimis (i.e.*, less than 0.50 percent *ad valorem*), in accordance with the requirement set forth in 19 CFR 351.106 (c) (2), we calculated customer–specific ad valorem ratios based on the export prices.

For SFTC, the company which was not selected for individual review and met the separate application status, we calculated an assessment rate based on the weighted–average margin calculated for the mandatory respondents, which are not *de minimis* or based on adverse facts available, in accordance with Department practice. We will instruct CBP to assess antidumping duties on this company's entries equal to the margin this company has received in the final results, regardless of the importer of, or customer who purchased its subject merchandise.

The other three companies for whom a review was requested, Anhui, Guangdong, and Tianjin, did not provide separate rate information. Therefore, the Department finds that they are not entitled to a separate rate. As a result, these three companies will be considered part of the PRC–wide entity. We will instruct CBP to liquidate entries for all companies in the PRC–wide entity at the PRC–wide rate of 114.90 percent.

For entries of the subject merchandise during the POR from companies not subject to this review, we will instruct CBP to liquidate them at the cash deposit rate in effect at the time of entry. The final results of this review shall be the basis for the assessment of antidumping duties on entries of merchandise covered by the final results of this review and for future deposits of estimated duties, where applicable.

Cash Deposit Requirements

The following cash–deposit requirements will apply to all shipments of certain cased pencils from the PRC entered, or withdrawn from warehouse, for consumption on or after the publication date of the final results of this administrative review, as provided by section 751(a)(1) of the Tariff Act of 1930, as amended (the ''Act''): (1) the cash deposit rates for the reviewed companies named above will be the rates for those firms established in the final results of this administrative review; (2) for any previously reviewed or investigated PRC or non–PRC exporter, not covered in this review, with a separate rate, the cash deposit rate will be the company–specific rate established in the most recent segment of this proceeding; (3) for all other PRC exporters, the cash deposit rate will be the PRC–wide rate established in the final results of this review which is 114.90 percent; and (4) the cash–deposit rate for any non–PRC exporter of subject merchandise from the PRC will be the rate applicable to the PRC exporter that

supplied that exporter. These deposit requirements, when imposed, shall remain in effect until further notice.

Notification to Interested Parties

This notice serves as a final reminder to importers of their responsibility under 19 CFR 351.402(f)(2) to file a certificate regarding the reimbursement of antidumping duties prior to liquidation of the relevant entries during this review period. Failure to comply with this requirement could result in the Secretary's presumption that reimbursement of antidumping duties occurred and the subsequent assessment of double antidumping duties.

This notice also serves as a final reminder to parties subject to the administrative protective order (''APO'') of their responsibility concerning the return or destruction of proprietary information disclosed under the APO in accordance with 19 CFR 351.305. Timely written notification of the return or destruction of APO materials or conversion to judicial protective order is hereby requested. Failure to comply with the regulations and the terms of an APO is a sanctionable violation.

This notice of final results is issued and published in accordance with sections 751(a)(1) and 777(i)(1) of the Act.

Dated: July 6, 2009.

John M. Andersen,

Acting Deputy Assistant Secretary for Antidumping and Countervailing Duty Operations.

Appendix Issues in Decision Memorandum

Comment 1: Collapsing Analysis
Comment 2: Three Star's Responses and Application of Adverse Facts Available
  a. Market Economy Purchase Claims
  b. Alleged Failure to Report Certain Information Warrants Application of AFA
Comment 3: Appropriate Labor Rate
Comment 4: Surrogate Values
  a. Slats
  b. Cores and Lacquer
  c. Castor Oil, Kaolin Clay, and Packing
  d. Steam Coal
Comment 5: Adjustment of the Pencil Slat Surrogate Value to Account for Wood Loss
Comment 6: Whether Certain WTA Data Are Aberrational
Comment 7: Correction of Clerical Errors
Comment 8: Use of Wrong Surrogate Value for ''Shell Card''

[FR Doc. E9–16511 Filed 7–10–09; 8:45 am]

BILLING CODE 3510–DS–S

DEPARTMENT OF COMMERCE

International Trade Administration

[A–533–840]

Certain Frozen Warmwater Shrimp From India: Final Results and Partial Rescission of Antidumping Duty Administrative Review

AGENCY: Import Administration, International Trade Administration, Department of Commerce.

SUMMARY: On March 9, 2009, the Department of Commerce (the Department) published the preliminary results of the administrative review of the antidumping duty order on certain frozen warmwater shrimp (shrimp) from India. This review covers 156 producers/exporters [1] of the subject merchandise to the United States. The period of review (POR) is February 1, 2007, through January 31, 2008.

After analyzing the comments received, we have made no changes in the margin calculations. Therefore, the final results do not differ from the preliminary results. The final weighted-average dumping margins for the reviewed firms are listed below in the section entitled ''Final Results of Review.''

DATES: *Effective Date:* July 13, 2009.

FOR FURTHER INFORMATION CONTACT: Elizabeth Eastwood or Henry Almond, AD/CVD Operations, Office 2, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue, NW., Washington, DC 20230; telephone (202) 482–3874 or (202) 482–0049, respectively.

SUPPLEMENTARY INFORMATION:

Background

This review covers 156 producers/exporters. The respondents which the Department selected for individual review are Devi Sea Foods Limited (Devi) and Falcon Marine Exports Limited (Falcon). The respondents which were not selected for individual review are listed in the ''Final Results of Review'' section of this notice.

On March 9, 2009, the Department published in the **Federal Register** the preliminary results of administrative review of the antidumping duty order on shrimp from India. *See Certain Frozen Warmwater Shrimp From India: Preliminary Results and Preliminary Partial Rescission of Antidumping Duty Administrative Review*, 74 FR 9991 (Mar. 9, 2009) (Preliminary Results).

We invited parties to comment on our preliminary results of review. In April 2009, we received case and rebuttal briefs from the petitioner (*i.e.*, the Ad Hoc Shrimp Trade Action Committee), a group of 32 U.S. shrimp processors,[2] and the two respondents selected for individual examination (*i.e.*, Devi and Falcon).

The Department has conducted this administrative review in accordance with section 751 of the Tariff Act of 1930, as amended (the Act).

Scope of the Order

The scope of this order includes certain frozen warmwater shrimp and prawns, whether wild-caught (ocean harvested) or farm-raised (produced by aquaculture), head-on or head-off, shell-on or peeled, tail-on or tail-off,[3] deveined or not deveined, cooked or raw, or otherwise processed in frozen form.

The frozen warmwater shrimp and prawn products included in the scope of this order, regardless of definitions in the Harmonized Tariff Schedule of the United States (HTSUS), are products which are processed from warmwater shrimp and prawns through freezing and which are sold in any count size.

The products described above may be processed from any species of warmwater shrimp and prawns. Warmwater shrimp and prawns are generally classified in, but are not limited to, the Penaeidae family. Some examples of the farmed and wild-caught warmwater species include, but are not limited to, whiteleg shrimp (*Penaeus vannemei*), banana prawn (*Penaeus merguiensis*), fleshy prawn (*Penaeus chinensis*), giant river prawn (*Macrobrachium rosenbergii*), giant tiger prawn (*Penaeus monodon*), redspotted shrimp (*Penaeus brasiliensis*), southern brown shrimp (*Penaeus subtilis*),

[1] Collapsed entities are treated as one producer/exporter.

[2] These companies are: (1) Bayou Shrimp Processors, Inc.; (2) Biloxi Freezing & Processing Co.; (3) CF Gollot and Son Seafood, Inc.; (4) Carson and Co., Inc.; (5) Custom Pack, Inc.; (6) Deep Sea Foods Inc./Jubilee Foods; (7) Dominick's Seafood, Inc.; (8) Dunamis Towing, Inc., (9) Fisherman's Reef Shrimp Co., Inc.; (10) Golden Gulf Coast Pkg. Co., Inc; (11) Gollott's Oil Dock and Ice House, Inc.; (12) Graham Fisheries; (13) Gulf Crown Seafood Co., Inc., (14) Gulf Fish, Inc.; (15) Gulf Pride Enterprises, Inc.; (16) Gulf Island Shrimp & Seafood, LLC; (17) Hi Seas of Dulac, Inc.; (18) JBS Packing Co., Inc.; (19) Lafitte Frozen Foods Corp.; (20) Louisiana Newpack Shrimp Co., Inc.; (21) Louisiana Shrimp & Packing Co., Inc.; (22) M&M Seafood; (23) Ocean Springs Seafood, Market, Inc.; (24) Pascagoula Ice & Freezer Co., Inc.; (25) Paul Piazza and Son, Inc.; (26) Pearl, Inc. d/b/a Indian Ridge Shrimp Co.; (27) Price Seafood, Inc.; (28) RA Lesso Brokerage Co., Inc.; (29) Sea Pearl Seafood Company, Inc., (30) Tidelands Seafood Co., Inc.; (31) Vincent Piazza Jr., & Sons Seafood, Inc.; and (32) Woods Fisheries and Country, Inc.

[3] ''Tails'' in this context means the tail fan, which includes the telson and the uropods.

southern pink shrimp (*Penaeus notialis*), southern rough shrimp (*Trachypenaeus curvirostris*), southern white shrimp (*Penaeus schmitti*), blue shrimp (*Penaeus stylirostris*), western white shrimp (*Penaeus occidentalis*), and Indian white prawn (*Penaeus indicus*).

Frozen shrimp and prawns that are packed with marinade, spices or sauce are included in the scope of this order. In addition, food preparations, which are not ''prepared meals,'' that contain more than 20 percent by weight of shrimp or prawn are also included in the scope of this order.

Excluded from the scope are: (1) Breaded shrimp and prawns (HTSUS subheading 1605.20.10.20); (2) shrimp and prawns generally classified in the *Pandalidae* family and commonly referred to as coldwater shrimp, in any state of processing; (3) fresh shrimp and prawns whether shell-on or peeled (HTSUS subheadings 0306.23.00.20 and 0306.23.00.40); (4) shrimp and prawns in prepared meals (HTSUS subheading 1605.20.05.10); (5) dried shrimp and prawns; (6) canned warmwater shrimp and prawns (HTSUS subheading 1605.20.10.40); (7) certain dusted shrimp; and (8) certain battered shrimp. Dusted shrimp is a shrimp-based product: (1) That is produced from fresh (or thawed-from-frozen) and peeled shrimp; (2) to which a ''dusting'' layer of rice or wheat flour of at least 95 percent purity has been applied; (3) with the entire surface of the shrimp flesh thoroughly and evenly coated with the flour; (4) with the non-shrimp content of the end product constituting between four and 10 percent of the product's total weight after being dusted, but prior to being frozen; and (5) that is subjected to IQF freezing immediately after application of the dusting layer. Battered shrimp is a shrimp-based product that, when dusted in accordance with the definition of dusting above, is coated with a wet viscous layer containing egg and/or milk, and par-fried.

The products covered by this order are currently classified under the following HTSUS subheadings: 0306.13.00.03, 0306.13.00.06, 0306.13.00.09, 0306.13.00.12, 0306.13.00.15, 0306.13.00.18, 0306.13.00.21, 0306.13.00.24, 0306.13.00.27, 0306.13.00.40, 1605.20.10.10, and 1605.20.10.30. These HTSUS subheadings are provided for convenience and for customs purposes only and are not dispositive, but rather the written description of the scope of this order is dispositive.

Period of Review

The POR is February 1, 2007, through January 31, 2008.

Partial Rescission

In the *Preliminary Results,* we assigned company-specific rates to Falcon, Manufacturer Falcon Marine Exports, Sandhya Aqua Exports, and Sandhya Aqua Exports Pvt. Ltd. However, after reviewing information from the 2008–2009 review, the Department has determined that two of these company names are duplicate names of the other two companies. The correct names of the companies listed in pairs above are Falcon and Sandhya Aqua Exports Pvt. Ltd. *See* the May 8, 2009, memorandum from Elizabeth Eastwood to the File, entitled, ''Placing Public Information from the 2008–2009 Antidumping Duty Administrative Review on the Record of the 2007–2008 Antidumping Duty Administrative Review on Certain Frozen Warmwater Shrimp from India'' (*Name Clarification Memo*). Therefore, the Department is rescinding this review with respect to Sandhya Aqua Exports and Manufacturer Falcon Marine Exports.

Collapsing

Prior to the *Preliminary Results,* one of the non-mandatory respondents in this case, Ananda Aqua Exports (AAE), informed the Department that it is affiliated with Ananda Foods (AF) and Ananda Aqua Applications (AAA), producers/exporters of shrimp in India. Consequently, it requested that the Department treat it and these two companies as a single entity for purposes of this administrative review. At the Department's request, AAE, AF, and AAA (hereinafter referred to as ''the Ananda Group'') provided information to support this claim. Although the Ananda Group's most recent submission, containing additional information with respect to the ownership of the three companies and the relationships among the owners, was filed in a timely manner, it was not received in time to consider for purposes of the preliminary results.

Nonetheless, in the *Preliminary Results* we preliminarily determined that, in accordance with 19 CFR 351.401(f), it is appropriate to collapse the companies in the Ananda Group for purposes of this proceeding because: (1) Entities within the group are affiliated and two of these entities have production facilities for identical or similar merchandise that would not require significant retooling in order to restructure manufacturing priorities; and (2) a significant potential for manipulation exists due to common ownership, overlapping management and board of directors, and intertwined operations. *See Preliminary Results,* 74 FR at 9994.

We have now analyzed the Ananda Group's March 2009 submission clarifying certain aspects of the companies' partners, including familial relationships of partners/owners of the three companies. Based on this additional information provided by the Ananda Group, we continue to find that it is appropriate to collapse the companies AAA, AAE, and AF into the Ananda Group, and consequently we have continued to treat these companies as a single entity for purposes of our final determination.

Cost of Production

As discussed in the preliminary results, we conducted an investigation to determine whether Devi and Falcon made third country sales of the foreign like product during the POR at prices below their costs of production (COP) within the meaning of section 773(b) of the Act. *See Preliminary Results,* 74 FR at 9997. For these final results, we performed the cost test following the same methodology as in the *Preliminary Results.*

We found 20 percent or more of each respondent's sales of a given product during the reporting period were at prices less than the weighted-average COP for this period. Thus, we determined that these below-cost sales were made in ''substantial quantities'' within an extended period of time and at prices which did not permit the recovery of all costs within a reasonable period of time in the normal course of trade. *See* sections 773(b)(1)–(2) of the Act.

Therefore, for purposes of these final results, we found that Devi and Falcon made below-cost sales not in the ordinary course of trade. Consequently, we disregarded these sales for each respondent and used the remaining sales as the basis for determining normal value pursuant to section 773(b)(1) of the Act.

Analysis of Comments Received

All issues raised in the case briefs by parties to this administrative review are listed in the Appendix to this notice and addressed in the Issues and Decision Memorandum (the Decision Memo), which is adopted by this notice. Parties can find a complete discussion of all issues raised in this review and the corresponding recommendations in this public memorandum, which is on file in the Central Records Unit, Room 1117, of the main Department building.

In addition, a complete version of the Decision Memo can be accessed directly on the Web at *http://ia.ita.doc.gov/frn/* . The paper copy and electronic version of the Decision Memo are identical in content.

Changes Since the Preliminary Results

Based on our analysis of the comments received, we have made no changes in the margin calculations.

Final Results of Review

We determine that the following weighted-average margin percentages exist for the period February 1, 2007, through January 31, 2008:

Manufacturer/exporter	Percent margin
Devi Sea Foods Limited	*0.39
Falcon Marine Exports Limited	0.79
Review-Specific Average Rate Applicable to the Following Companies: [4]	
Abad Fisheries	0.79
Accelerated Freeze-Drying Co	0.79
Allana Frozen Foods Pvt. Ltd	0.79
Allanasons Ltd	0.79
AMI Enterprises	0.79
Amulya Sea Foods	0.79
Anand Aqua Exports	0.79
Ananda Aqua Exports (P) Ltd./Ananda Foods/Ananda Aqua Applications	0.79
Andaman Seafoods Pvt. Ltd	0.79
Angelique Intl	0.79
Anjaneya Seafoods	0.79
Apex Exports	0.79
Asvini Exports	0.79
Asvini Fisheries Private Limited	0.79
Avanti Feeds Limited	0.79
Ayshwarya Seafood Private Limited	0.79
Baby Marine International	0.79
Baby Marine Sarass	0.79
Bhatsons Aquatic Products	0.79
Bhavani Seafoods	0.79
Bijaya Marine Products	0.79
Blue Water Foods & Exports P. Ltd	0.79
Bluefin Enterprises	0.79
Bluepark Seafoods Pvt. Ltd	0.79
BMR Exports	0.79
Britto Exports	0.79
Calcutta Seafoods	0.79
Calcutta Seafoods Pvt. Ltd	0.79
Castlerock Fisheries Ltd	0.79
Chemmeens (Regd)	0.79
Choice Canning Company	0.79
Choice Trading Corporation Pvt. Ltd	0.79
Coastal Corporation Ltd	0.79
Corlim Marine Exports Pvt. Ltd	0.79
Coreline Exports	0.79
Devi Fisheries Limited	0.79
Digha Seafood Exports	0.79
Esmario Export Enterprises	0.79
Exporter Coreline Exports	0.79
Five Star Marine Exports Private Limited	0.79
Forstar Frozen Foods Pvt. Ltd	0.79
Frigerio Conserva Allana Limited	0.79
Frontline Exports Pvt. Ltd	0.79
G A Randerian Ltd	0.79
Gadre Marine Exports	0.79
Galaxy Maritech Exports P. Ltd	0.79
Gayatri Seafoods	0.79
Geo Aquatic Products (P) Ltd	0.79
Geo Seafoods	0.79
Grandtrust Overseas (P) Ltd	0.79
GVR Exports Pvt. Ltd	0.79
HIC ABF Special Foods Pvt. Ltd	0.79
Haripriya Marine Export Pvt. Ltd	0.79
Hindustan Lever, Ltd	0.79
Hiravata Ice & Cold Storage	0.79
Hiravati Exports Pvt. Ltd	0.79
Hiravati International Pvt. Ltd. (located at Jawar Naka, Porbandar, Gujarat—360 575, India)	0.79
Hiravati International Pvt. Ltd. (located at APM-Mafco Yard, Sector—18 Vashi, Navi, Mumbai—400 705, India)	0.79
IFB Agro Industries Limited	0.79
Indian Aquatic Products	0.79
Indo Aquatics	0.79
Innovative Foods Limited	0.79
International Freezefish Exports	0.79

Manufacturer/exporter	Percent margin
Interseas	0.79
ITC Ltd	0.79
Jagadeesh Marine Exports	0.79
Jaya Satya Marine Exports	0.79
Jaya Satya Marine Exports Pvt. Ltd	0.79
Jayalakshmi Sea Foods Private Limited	0.79
Jinny Marine Traders	0.79
Jiya Packagings	0.79
K R M Marine Exports Ltd	0.79
Kalyanee Marine	0.79
Kay Kay Exports	0.79
Kings Marine Products	0.79
Koluthara Exports Ltd	0.79
Konark Aquatics & Exports Pvt. Ltd	0.79
Libran Cold Storages (P) Ltd	0.79
Magnum Estate Private Limited	0.79
Magnum Export	0.79
Magnum Sea Foods Pvt. Ltd	0.79
Malabar Arabian Fisheries	0.79
Malnad Exports Pvt. Ltd	0.79
Mangala Marine Exim India Private Ltd	0.79
Mangala Sea Products	0.79
MSC Marine Exporters	0.79
MTR Foods	0.79
Naga Hanuman Fish Packers	0.79
Naik Frozen Foods	0.79
Navayuga Exports Ltd	0.79
Nekkanti Sea Foods Limited	0.79
NGR Aqua International	0.79
Nila Sea Foods Pvt. Ltd	0.79
Overseas Marine Export	0.79
Penver Products (P) Ltd	0.79
Pijikay International Exports P Ltd	0.79
Pisces Seafood International	0.79
Premier Seafoods Exim (P) Ltd	0.79
Raa Systems Pvt. Ltd	0.79
Raju Exports	0.79
Ram's Assorted Cold Storage Ltd	0.79
Raunaq Ice & Cold Storage	0.79
Raysons Aquatics Pvt. Ltd	0.79
Razban Seafoods Ltd	0.79
RBT Exports	0.79
Riviera Exports Pvt. Ltd	0.79
Rohi Marine Private Ltd	0.79
RVR Marine Products Private Limited	0.79
S A Exports	0.79
S Chanchala Combines	0.79
S & S Seafoods	0.79
Safa Enterprises	0.79
Sagar Foods	0.79
Sagar Grandhi Exports Pvt. Ltd	0.79
Sagarvihar Fisheries Pvt. Ltd	0.79
Sai Marine Exports Pvt. Ltd	0.79
Sai Sea Foods	0.79
Sai Sea Foods a.k.a. Sai Marine Exports Pvt. Ltd	0.79
Sandhya Aqua Exports Pvt. Ltd	0.79
Sandhya Marines Limited	0.79
Santhi Fisheries & Exports Ltd	0.79
Satya Seafoods Private Limited	0.79
Sawant Food Products	0.79
Seagold Overseas Pvt. Ltd	0.79
Selvam Exports Private Limited	0.79
Shippers Exports	0.79
Shroff Processed Food & Cold ZStorage P Ltd	0.79
Silver Seafood	0.79
Sita Marine Exports	0.79
Sprint Exports Pvt. Ltd	0.79
Sri Chandrakantha Marine Exports [5]	0.79
Sri Sakkthi Cold Storage	0.79
Sri Sakthi Marine Products P Ltd	0.79
Sri Satya Marine Exports	0.79
Sri Venkata Padmavathi Marine Foods Pvt. Ltd	0.79
SSF Ltd	0.79

Manufacturer/exporter	Percent margin
Star Agro Marine Exports Private Limited	0.79
Sun Bio-Technology Ltd	0.79
Suryamitra Exim (P) Ltd	0.79
Suvarna Rekha Exports Private Limited	0.79
Suvarna Rekha Marines P Ltd	0.79
TBR Exports Pvt Ltd	0.79
Teekay Marine P. Ltd.[6]	0.79
The Kadalkanny Group (Kadalkanny Frozen Foods, Edhayam Frozen Foods Pvt. Ltd., Diamond Seafoods Exports, and Theva & Company)	0.79
The Liberty Group (Devi Marine Food Exports Private Limited/Kader Exports Private Limited/Kader Investment and Trading Company Private Limited/Liberty Frozen Foods Pvt. Ltd./Liberty Oil Mills Ltd./Premier Marine Products/Universal Cold Storage Private Limited)	0.79
The Waterbase Limited	0.79
Tejaswani Enterprises	0.79
Usha Seafoods	0.79
V.S Exim Pvt Ltd	0.79
Veejay Impex	0.79
Victoria Marine & Agro Exports Ltd	0.79
Vinner Marine	0.79
Vishal Exports	0.79
Wellcome Fisheries Limited	0.79

* *De minimis*.

Assessment

The Department shall determine, and Customs and Border Protection (CBP) shall assess, antidumping duties on all appropriate entries.

Pursuant to 19 CFR 351.212(b)(1), because Devi and Falcon reported the entered value for some or all of their U.S. sales, we have calculated importer-specific *ad valorem* duty assessment rates based on the ratio of the total amount of antidumping duties calculated for the examined sales to the total entered value of the sales which entered value was reported. For Falcon's U.S. sales reported without entered values, we have calculated importer-specific per-unit duty assessment rates by aggregating the total amount of antidumping duties calculated for the examined sales and dividing this amount by the total quantity of those sales. To determine whether the duty assessment rates are *de minimis*, in accordance with the requirement set forth in 19 CFR 351.106(c)(2), we have calculated importer-specific *ad valorem* ratios based on the estimated entered value.

For the companies which were not selected for individual review, we have calculated an assessment rate based on the weighted average of the cash deposit rates calculated for the companies selected for individual review excluding any which are *de minimis* or determined entirely on AFA.

Pursuant to 19 CFR 351.106(c)(2), we will instruct CBP to liquidate without regard to antidumping duties any entries for which the assessment rate is *de minimis* (*i.e.*, less than 0.50 percent). The Department intends to issue assessment instructions to CBP 15 days after the date of publication of these final results of review.

The Department clarified its ''automatic assessment'' regulation on May 6, 2003. *See Antidumping and Countervailing Duty Proceedings: Assessment of Antidumping Duties,* 68 FR 23954 (May 6, 2003). This clarification will apply to entries of subject merchandise during the POR produced by companies included in these final results of review for which the reviewed companies did not know their merchandise was destined for the United States. In such instances, we will instruct CBP to liquidate unreviewed entries at the all-others rate established in the less-than-fair-value (LTFV) investigation if there is no rate for the intermediate company(ies) involved in the transaction.

Cash Deposit Requirements

Further, the following deposit requirements will be effective for all shipments of shrimp from India entered, or withdrawn from warehouse, for consumption on or after the publication date of the final results of this administrative review, as provided for by section 751(a)(2)(C) of the Act: (1) The cash deposit rates for the reviewed companies will be the rates shown above, except if the rate is less than 0.50 percent, *de minimis* within the meaning of 19 CFR 351.106(c)(1), the cash deposit will be zero; (2) for previously investigated companies not listed above, the cash deposit rate will continue to be the company-specific rate published for the most recent period; (3) if the exporter is not a firm covered in this review, or the LTFV investigation, but the manufacturer is, the cash deposit rate will be the rate established for the most recent period for the manufacturer of the merchandise; and (4) the cash deposit rate for all other manufacturers or exporters will continue to be 10.17 percent, the all-others rate established in the LTFV investigation. *See Notice of Amended Final Determination of Sales at Less Than Fair Value and Antidumping Duty Order: Certain Frozen Warmwater Shrimp from India,* 70 FR 5147, 5148 (Feb. 1, 2005). These deposit requirements shall remain in effect until further notice.

Notification to Importers

This notice serves as a final reminder to importers of their responsibility, under 19 CFR 351.402(f)(2), to file a certificate regarding the reimbursement of antidumping duties prior to

[4] This rate is based on the weighted average of the margins calculation for those companies selected for individual review, excluding *de minimis* margins or margins based entirely on adverse facts available (AFA).

[5] The Department initiated the 2007–2008 administrative review for this company under the name Sri Chandrakantha Marine Exports, Ltd. However, subsequent to the *Preliminary Results,* we discovered that the company's correct name is Sri Chandrakantha Marine Exports. *See Name Clarification Memo.* Therefore, we have included this company in our final results under its correct name.

[6] The Department initiated the 2007–2008 administrative review for this company under the name Teekay Maine P. Ltd. However, subsequent to the *Preliminary Results,* we discovered that the company's correct name is Teekay Marine P. Ltd. *See Name Clarification Memo.* Therefore, we have included this company in our final results under its correct name.

liquidation of the relevant entries during this review period. Failure to comply with this requirement could result in the Secretary's presumption that reimbursement of antidumping duties occurred and the subsequent assessment of double antidumping duties.

Notification to Interested Parties

This notice serves as the only reminder to parties subject to administrative protective order (APO) of their responsibility concerning the disposition of proprietary information disclosed under APO in accordance with 19 CFR 351.305(a)(3). Timely written notification of return/ destruction of APO materials or conversion to judicial protective order is hereby requested. Failure to comply with the regulations and the terms of an APO is a sanctionable violation.

We are issuing and publishing these results of review in accordance with sections 751(a)(1) and 777(i)(1) of the Act.

Dated: July 7, 2009.

Ronald K. Lorentzen,

Acting Assistant Secretary for Import Administration.

Appendix—Issues in Decision Memorandum

General Issues

1. Offsetting of Negative Margins
2. Using U.S. CBP Data for Respondent Selection
3. The Calculation of the Assessment Rate Assigned to Companies Receiving the Review-Specific Average Rate
4. Model Matching Methodology

Company-Specific Issues

5. The Calculation of Falcon's General and Administrative Expense Ratio

[FR Doc. E9–16516 Filed 7–10–09; 8:45 am]

BILLING CODE 3510–DS–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

RIN 0648–XP76

Fisheries of the Caribbean, Gulf of Mexico, and South Atlantic; Reef Fish of the Gulf of Mexico; Exempted Fishing Permit

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice of receipt of an application for an exempted fishing permit; request for comments.

SUMMARY: NMFS announces the receipt of an application for an exempted fishing permit (EFP) from the Florida Fish and Wildlife Conservation Commission, Fish and Wildlife Research Institute. This study would place observers aboard vessels of opportunity in the Gulf of Mexico recreational for–hire fishery to collect reef fish for determination of age structure and sex composition and to tag and release reef fish to evaluate discard mortality. If granted, the EFP would authorize the applicant, within certain conditions, to collect and possess reef fish that would otherwise be prohibited because of existing fishing regulations.

DATES: Comments must be received no later than 5 p.m., eastern time, on August 12, 2009.

ADDRESSES: You may submit comments on the application by any of the following methods:

• E–mail: *Rich.Malinowski@noaa.gov*. Include in the subject line of the e–mail comment the following document identifier: ''FFWCC_EFP''.

• Mail: Rich Malinowski, Southeast Regional Office, NMFS, 263 13th Avenue South, St. Petersburg, FL 33701.

• Fax: 727–824–5308.

The application and related documents are available for review upon written request to any of the above addresses.

FOR FURTHER INFORMATION CONTACT: Rich Malinowski, 727–824–5305; fax 727–824–5308; e–mail *Rich.Malinowski@noaa.gov*.

SUPPLEMENTARY INFORMATION: The EFP is requested under the authority of the Magnuson–Stevens Fishery Conservation and Management Act (16 U.S.C. 1801 *et seq.*), and regulations at 50 CFR 600.745(b) concerning exempted fishing.

The described research is part of a Cooperative Research Program Grant and the Emergency Disaster Relief Program. The Cooperative Research Program is a means of involving commercial and/or recreational fishermen in the collection of fundamental fisheries information. Resource collection efforts support the development and evaluation of fisheries management and regulatory options. The Emergency Disaster Relief Program is administered by the Gulf States Marine Fisheries Commission, to assist in an assessment of the status of the for–hire fishery fleets operating in counties impacted by the 2005 hurricane season.

The proposed collection for scientific research involves activities otherwise prohibited by regulations implementing the Fishery Management Plan for the Reef Fish Resources of the Gulf of Mexico. The applicants require authorization to harvest and possess snapper and grouper species for scientific research activities during the period from June 15, 2009, through June 15, 2012. Specimens would be collected from Federal waters off the west coast of Florida. Sampling would occur during normal fishing operations of the recreational for–hire fishery. Data collections for this study would support improved information about the catch, bycatch, discards, discard mortality, age structure and sex determinations for species in the reef fish complex. These data would provide insight on a stock's resilience to fishing and would help refine estimates of long–term biological productivity of the stocks. It is anticipated project results would yield valuable data within this fishery.

NMFS finds this application warrants further consideration. Based on a preliminary review, NMFS intends to issue an EFP. Possible conditions the agency may impose on this permit, if it is indeed granted, include but are not limited to, a prohibition of conducting research within marine protected areas, marine sanctuaries, or special management zones, without additional authorization. Additionally, NMFS may prohibit the possession of Nassau or goliath grouper and would require any sea turtles taken incidentally during the course of fishing or scientific research activities to be handled with due care to prevent injury to live specimens, observed for activity, and returned to the water. A final decision on issuance of the EFP will depend on a NMFS review of public comments received on the application, consultations with the affected states, the Gulf of Mexico Fishery Management Council, and the U.S. Coast Guard, and a determination that it is consistent with all applicable laws.

Authority: 16 U.S.C. 1801 *et seq.*

Dated: July 8, 2009.

Kristen C. Koch

Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. E9–16666 Filed 7–10–09; 8:45 am]

BILLING CODE 3510–22–S

DEPARTMENT OF COMMERCE

Foreign–Trade Zones Board

[Docket 26–2009]

Foreign–Trade Zone 73 - Baltimore/ Washington International Airport, MD, Application for SubzoneIKEA Wholesale, Inc. (Home furnishings and accessories), Perryville, MD

An application has been submitted to the Foreign–Trade Zones Board (the Board) by the Maryland Department of Transportation/ Maryland Aviation Administration, grantee of FTZ 73, requesting special–purpose subzone status for the warehousing and distribution facility of IKEA Wholesale Inc. (IKEA), located in Perryville, Maryland. The application was submitted pursuant to the provisions of the Foreign–Trade Zones Act, as amended (19 U.S.C. 81a–81u), and the regulations of the Board (15 CFR part 400). It was formally filed on July 2, 2009.

The IKEA facility (400 full–time and part–time employees, 242 acres/ 1.7 million square feet) is located at 100 Ikea Way, Perryville, Maryland. The facility is used for the storage and distribution of merchandise that includes: housewares and home furnishings, home textiles, glassware, kitchenware, appliances, cutlery, furniture, flooring and floor coverings, window treatments and fixtures, lighting fixtures, lamps, electrical products, batteries, hand tools, closet and storage accessories, office accessories, paper products, computers, CDs and DVDs, clocks and timers, toys, sporting goods, seasonal decorations, home recreation/entertainment items, and brooms and brushes (duty rate range: from free to 38%).

FTZ procedures could exempt IKEA from customs duty payments on the foreign goods exported from the proposed subzone. The company anticipates that some 25 percent of the facility's shipments will be exported. On its domestic sales, the company would be able to defer duty payments until merchandise is shipped from the facility and entered for consumption. FTZ designation would further allow IKEA to realize logistical benefits through the use of weekly customs entry procedures. The request indicates that the savings from FTZ procedures would help improve the facility's international competitiveness.

In accordance with the Board's regulations, Pierre Duy of the FTZ Staff is designated examiner to evaluate and analyze the facts and information presented in the application and case record and to report findings and recommendations to the Board.Public comment is invited from interested parties. Submissions (original and 3 copies) shall be addressed to the Board's Executive Secretary at the address below. The closing period for their receipt is September 11, 2009. Rebuttal comments in response to material submitted during the foregoing period may be submitted during the subsequent 15-day period to September 28, 2009.

A copy of the application will be available for public inspection at the Office of the Executive Secretary, Foreign–Trade Zones Board, Room 2111, U.S. Department of Commerce, 1401 Constitution Avenue, NW, Washington, DC 20230–0002, and in the ''Reading Room'' section of the Board's website, which is accessible via www.trade.gov/ftz.

For further information, contact Pierre Duy at: pierre__duy@ita.doc.gov, or (202) 482–1378.

Dated: July 2, 2009.

Andrew McGilvray,

Executive Secretary.

[FR Doc. E9–16515 Filed 7–10–09; 8:45 am]

BILLING CODE 3510–DS–S

DEPARTMENT OF COMMERCE

Foreign–Trade Zones Board

Order No. 1627

Grant of Authority For Subzone Status, Black & Decker Corporation (Power Tools, Lawn and Garden Tools and Home Products Warehousing and Distribution), Jackson, Tennessee

Pursuant to its authority under the Foreign–Trade Zones Act of June 18, 1934, as amended (19 U.S.C. 81a–81u), the Foreign–Trade Zones Board (the Board) adopts the following Order:

Whereas, the Foreign–Trade Zones Act provides for '' . . . the establishment . . . of foreign–trade zones in ports of entry of the United States, to expedite and encourage foreign commerce, and for other purposes,'' and authorizes the Foreign–Trade Zones Board to grant to qualified corporations the privilege of establishing foreign–trade zones in or adjacent to U.S. Customs and Border Protection ports of entry;

Whereas, the Board's regulations (15 CFR Part 400) provide for the establishment of special–purpose subzones when existing zone facilities cannot serve the specific use involved, and when the activity results in a significant public benefit and is in the public interest;

Whereas, the City of Memphis, Tennessee, grantee of FTZ 77, has made application to the Board for authority to establish special–purpose subzone status at the power tools/lawn and garden tools and home products warehousing and distribution facilities of Black & Decker Corporation, located in Jackson, Tennessee (FTZ Docket 44–2008, filed 8/5/2008);

Whereas, notice inviting public comment has been given in the **Federal Register** (73 FR 47585, 8/14/2008); and,

Whereas, the Board adopts the findings and recommendations of the examiner's report, and finds that the requirements of the FTZ Act and the Board's regulations are satisfied, and that approval of the application is in the public interest;

Now, therefore, the Board hereby grants authority for subzone status for activity related to power tools/lawn and garden tools and home products warehousing and distribution at the Black & Decker Corporation facility located in Jackson, Tennessee (Subzone 77D), as described in the application and **Federal Register** notice, and subject to the FTZ Act and the Board's regulations, including Section 400.28.

Signed at Washington, DC, this 26th day of June 2009.

Ronald K. Lorentzen,

Acting Assistant Secretary of Commercefor Import Administration, Alternate Chairman, Foreign–Trade Zones Board

Attest:

Andrew McGilvray,

Executive Secretary.

[FR Doc. E9–16513 Filed 7–10–09; 8:45 am]

BILLING CODE 3510–DS–S

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

RIN 0648–XQ06

Magnuson–Stevens Act Provisions; General Provisions for Domestic Fisheries; Application for Exempted Fishing Permits

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and AtmosphericAdministration (NOAA), Commerce.

ACTION: Notification of a proposal to conduct exempted fishing; request for comments.

SUMMARY: The Assistant Regional Administrator for Sustainable Fisheries, Northeast Region, NMFS (Assistant Regional Administrator), has made a preliminary determination that the subject Exempted Fishing Permit (EFP) application that was submitted by the

Cornell Cooperative Extension of Suffolk County (CCE) warrants further consideration and should be issued for public comment. The EFP would exempt participating vessels from summer flounder size restrictions and summer flounder minimum mesh size regulations. The Assistant Regional Administrator has also made a preliminary determination that the activities authorized under the EFP would be consistent with the goals and objectives of the Summer Flounder, Scup, and Black Sea Bass Fishery Management Plan (FMP). However, further review and consultation may be necessary before a final determination is made.

DATES: Comments must be received on or before July 28, 2009.

ADDRESSES: Comments may be submitted by e–mail to: *nero.efp@noaa.gov*. Include in the subject line of the e–mail comment the following document identifier: ''Comments on CCE Inshore Fluke Discard EFP.'' Written comments should be sent to Patricia A. Kurkul, Regional Administrator, NMFS, Northeast Regional Office, 55 Great Republic Drive, Gloucester, MA 01930. Mark the outside of the envelope, ''Comments on CCE Inshore Fluke Discard EFP.'' Comments may also be sent via facsimile (fax) to (978) 281–9135.

FOR FURTHER INFORMATION CONTACT: Anna Macan, Fishery Management Specialist, phone: 978–281–9165, fax: 978–281–9135.

SUPPLEMENTARY INFORMATION: In 2007, the Science and Research Director for NMFS's Northeast Fisheries Science Center selected the proposal submitted by the CCE under the Summer Flounder, Scup, and Black Sea Bass Research Set–Aside (RSA) titled: ''Evaluation of Summer Flounder Discard Mortality in the Bottom Trawl Fishery.'' The research was conducted to improve and enhance fishery information relative of discard mortality of summer flounder in the bottom trawl fishery. An extension to utilize available funds was granted to CCE, so an EFP to conduct additional research trips is being requested.

This EFP would allow for additional research trips to further enhance the existing data on mortality of trawl–caught summer flounder. The research would be carried out from July 2009 through July 2010, up to a total of 10 research trips, and would be in conjunction with normal fishing operations of the mixed trawl fishery. Only one vessel would be used for each trip, but up to six vessels could be used, depending on availability. Vessels would be compensated to make three specific tows for summer flounder to assess trawl mortality. Duration of these tows would be 1, 2, and 3 hours. Summer flounder from each tow would be culled and sorted between live and dead. Sorting would occur at predetermined time intervals until the deck is cleared of fish. The fish would then be weighed and, as time allows, scale and otolith samples from both groups would be collected. The research trips would be conducted inshore along the coast of southern Long Island from Jones Inlet to Montauk Point, reaching depths of 240 ft (73 m). Areas sampled would include NMFS statistical areas 611, 612, and 613. In order to conduct the research, the vessels would need exemptions from the summer flounder minimum fish size and mesh size regulations at §§ 648.103 and 648.104(a)(1), respectively. These exemptions are needed to retain the fish on deck for the purpose of scientific research. Additionally, since the research trips may be conducted during a commercial squid trip, an exemption from the summer flounder minimum mesh size regulation is also needed in order for the vessels to retain more than the incidental limit of 100 lb (45.4 kg) of summer flounder. After the research, is conducted the fish would be returned to sea, unless the vessel is currently allocated 2009 research set– aside and has been issued a current and separate EFP to harvest research set–aside quota.

Regulations under the Magnuson ndash;Stevens Fishery Conservation and Management Act require publication of this notification to provide interested parties the opportunity to comment on applications for proposed EFPs. The applicant may place requests for minor modifications and extensions to the EFP throughout the year. EFP modifications and extensions may be granted without further notice if they are deemed essential to facilitate completion of the proposed research and minimal so as not to change the scope or impact of the initially approved EFP request.

Authority: 16 U.S.C. 1801 *et seq.*

Dated: July 8, 2009.

Kristen C. Koch

Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. E9–16528 Filed 7–10–09; 8:45 am]

BILLING CODE 3510–22–S

DEPARTMENT OF COMMERCE

Patent and Trademark Office

[Docket No. PTO–T–2009–0026]

Trademark Examination Guides 01–09 and 02–09 on Deceptiveness Refusals

AGENCY: United States Patent and Trademark Office, Commerce.

ACTION: Notice

SUMMARY: The United States Patent and Trademark Office (''USPTO'' or ''Office'') is publishing two Trademark Examination Guides (''Guides'') regarding deceptiveness refusals for non-geographic and geographic marks. These Guides, issued on May 11, 2009, are being published to give members of the public notice of them in addition to the notice already provided on the USPTO's Web site. Members of the public may submit comments regarding the Guides. Comments will be given consideration in connection with developing future examination guidance dealing with the subjects of the Guides.

ADDRESSES: The Office prefers that any comments be submitted via electronic mail message to *TMFRNotices@uspto.gov*. Written comments may also be submitted by mail addressed to: Commissioner for Trademarks, P.O. Box 1451, Alexandria, VA 22313–1451, marked to the attention of Cynthia C. Lynch; or by hand delivery to the Trademark Assistance Center, Concourse Level, James Madison Building—East Wing, 600 Dulany Street, Alexandria, Virginia, marked to the attention of Cynthia C. Lynch.

The comments will be available for public inspection on the Office's Web site at *http://www.uspto.gov* and will also be available at the Office of the Commissioner for Trademarks, Madison East, Tenth Floor, 600 Dulany Street, Alexandria, Virginia. Because comments will be made available for public inspection, information that is not desired to be made public, such as an address or phone number, should not be included in the comments.

FOR FURTHER INFORMATION CONTACT: Cynthia C. Lynch, Office of the Deputy Commissioner for Trademark Examination Policy, by electronic mail at: *cynthia.lynch@uspto.gov;* or by mail addressed to: Commissioner for Trademarks, P.O. Box 1451, Alexandria, VA 22313–1451, marked to the attention of Cynthia C. Lynch.

SUPPLEMENTARY INFORMATION: On May 11, 2009, the Office issued Examination Guides 01–09 and 02–09 regarding examination procedures for marks that may be deceptive under either section

2(a) or section 2(e)(3). Section 2(a) of the Trademark Act, 15 U.S.C. 1052(a), prohibits, inter alia, the registration of deceptive matter. Section 2(e)(3) of the Trademark Act, 15 U.S.C. 1052(e)(3), prohibits the registration of primarily geographically deceptively misdescriptive marks. Each Guide reviews and discusses case law regarding: (1) The elements of the refusal; (2) evidentiary issues with respect to the refusal; and (3) procedures for issuing refusals. The Guides may be found on the Office's Web site at: *http://www.uspto.gov/web/offices/tac/notices/notices.htm*.

The purpose of these Guides is to promote consistency in examination and to provide guidance to examining attorneys regarding when deceptiveness refusals must be issued. These Guides do not constitute substantive rulemaking and hence do not have the force and effect of law. They have been developed as a matter of internal Office management and are not intended to create any right or benefit, substantive or procedural, enforceable by any party against the Office. To the extent that earlier guidance from the Office, including certain sections of the Trademark Manual of Examining Procedure (TMEP), 5th edition, is inconsistent with the guidance set forth in the Guides, Office personnel are to follow the Guides. The next revision of the TMEP will be updated accordingly.

Any member of the public may submit written comments on either or both of the Guides. The Office will consider any comments received in connection with developing future examination guidance dealing with the subjects of the Guides. Persons submitting comments should note that the USPTO does not plan to provide a response to or analysis of any comments, as these Guides are not notices of proposed rulemaking.

Dated: July 6, 2009.

John J. Doll,

Acting Under Secretary of Commerce for Intellectual Property and Acting Director of the United States Patent and Trademark Office.

[FR Doc. E9–16424 Filed 7–10–09; 8:45 am]

BILLING CODE 3510–16–P

CONSUMER PRODUCT SAFETY COMMISSION

Proposed Extension of Approval of Information Collection; Comment Request-Safety Standard for Walk-Behind Power Lawn Mowers

AGENCY: Consumer Product Safety Commission.

ACTION: Notice.

SUMMARY: As required by the Paperwork Reduction Act (44 U.S.C. Chapter 35), the Consumer Product Safety Commission (CPSC or Commission) requests comments on a proposed request for an extension of approval of a collection of information from manufacturers and importers of walk-behind power lawn mowers. This collection of information consists of testing and recordkeeping requirements in certification regulations implementing the Safety Standard for Walk-Behind Power Lawn Mowers (16 CFR Part 1205). The Commission will consider all comments received in response to this notice before requesting an extension of approval of this collection of information from the Office of Management and Budget (OMB).

DATES: The Office of the Secretary must receive written comments not later than September 11, 2009.

ADDRESSES: Written comments should be captioned ''Walk-Behind Power Lawn Mowers'' and sent by e-mail to *cpsc-os@cpsc.gov.* Written comments may also be sent to the Office of the Secretary by facsimile at (301) 504–0127, or by mail to the Office of the Secretary, Consumer Product Safety Commission, Room 502, 4330 East-West Highway, Bethesda, MD 20814.

FOR FURTHER INFORMATION CONTACT: For information about the proposed collection of information call or write Linda Glatz, Division of Policy and Planning, Office of Information Technology and Technology Services, Consumer Product Safety Commission, 4330 East-West Highway, Bethesda, MD 20814; telephone: (301) 504–7671 or by e-mail to *lglatz@cpsc.gov.*

SUPPLEMENTARY INFORMATION: In 1979, the Commission issued the Safety Standard for Walk-Behind Power Lawn Mowers (16 CFR Part 1205) under provisions of the Consumer Product Safety Act (CPSA) (15 U.S.C. 2051 *et seq.*) to eliminate or reduce risks of amputations, avulsions, lacerations, and other serious injuries which have resulted from the accidental contact of some part of an operator's body with the rotating blade of a power lawn mower. The standard contains performance and labeling requirements for walk-behind power lawn mowers to address risks of blade-contact injuries.

A. Certification Requirements

Section 14(a) of the CPSA (15 U.S.C. 2063(a)) requires manufacturers, importers, and private labelers of a consumer product subject to a consumer product safety standard under the CPSA or similar rule, ban, standard, or regulation under any other act enforced by the Commission to issue a certificate stating that the product complies with all applicable rules, bans, standards or regulations. Section 14(a) of the CPSA also requires that the certificate of compliance must be based on a test of each product or upon a reasonable testing program and specify each such rule, ban, standard or regulation applicable to the product.

Section 14(b) of the CPSA (15 U.S.C. 2063(b)) authorizes the Commission to issue regulations to prescribe a reasonable testing program to support certificates of compliance with a consumer product safety standard under the CPSA or similar rule, ban, standard, or regulation under any other act enforced by the Commission. Section 16(b) of the CPSA (15 U.S.C. 2065(b)) authorizes the Commission to issue rules to require that firms ''establish and maintain'' records to permit the Commission to determine compliance with rules issued under the authority of the CPSA.

The Commission has issued regulations prescribing requirements for a reasonable testing program to support certificates of compliance with the standard for walk-behind power mowers under the CPSA. These regulations also require manufacturers, importers, and private labelers of walk-behind power mowers to establish and maintain records to demonstrate compliance with the requirements for testing to support certification of compliance. 16 CFR Part 1205, Subpart B.

The Commission uses the information compiled and maintained by manufacturers and importers of walk-behind power mowers to protect consumers from risks of injuries associated with walk-behind power lawn mowers. More specifically, the Commission uses this information to determine whether the mowers produced and imported comply with the applicable standard. The Commission also uses this information to obtain corrective actions if walk-behind power mowers fail to comply with the standard in a manner which creates a substantial risk of injury to the public.

OMB approved the collection of information requirements for walk-behind mowers under control number 3041–0091. OMB's most recent extension of approval will expire on September 30, 2009. The Commission proposes to request an extension of approval for these collection of information requirements.

B. Estimated Burden

The Commission staff estimates that about 20 firms are subject to the testing and recordkeeping requirements of the certification regulations. The Commission staff estimates further that the annual testing and recordkeeping burden imposed by the regulations on each of these firms on average is approximately 390 hours if 3 hours are expended by each firm over 130 estimated seasonal production days each year. The estimated annual burden imposed by the testing and recordkeeping requirements on all manufacturers and importers of walk-behind power mowers is 7,800 hours.

In addition, the manufacturer is required to include permanent labels attached to the lawn mowers. The Commission staff estimates an additional hour per production day to collect the information and place it on the label. Accordingly an additional 130 hours per firm is added to the total burden. For the 20 firms, the estimated additional burden related to labeling is 2,600 hours. The estimated total burden hours related to testing recordkeeping and labeling is 520 hours per firm and 10,400 hours for the industry.

Annual testing and recordkeeping costs burden is estimated to be $428,064 based on 7,800 hours × 54.88 (the average hourly total compensation for U.S. management, professional, and related occupations in goods-producing industries, Bureau of Labor Statistics, September 2008). Annual costs burden for labeling is estimated to be $70,564 based on 2,600 hours × $27.14 (the average hourly total compensation for sales and office workers in goods-producing industries, Bureau of Labor Statistics, September 2008). The total estimated burden costs related to testing, recordkeeping, and labeling to the industry is $498,626.

The Commission staff will expend approximately one half of one staff month reviewing records required to be maintained for walk-behind power lawn mowers. The annual cost to the Federal government of the collection of information in these regulations is estimated to be $6,920.

C. Request for Comments

The Commission solicits written comments from all interested persons about the proposed collection of information. The Commission specifically solicits information relevant to the following topics:

—Whether the collection of information described above is necessary for the proper performance of the Commission's functions, including whether the information would have practical utility;
—Whether the estimated burden of the proposed collection of information is accurate;
—Whether the quality, utility, and clarity of the information to be collected could be enhanced; and
—Whether the burden imposed by the collection of information could be minimized by use of automated, electronic or other technological collection techniques, or other forms of information technology.

Dated: July 7, 2009.

Todd A. Stevenson,

Secretary, Consumer Product Safety Commission.

[FR Doc. E9–16469 Filed 7–10–09; 8:45 am]

BILLING CODE 6355–01–P

DEPARTMENT OF DEFENSE

Office of the Secretary

[Docket No. DoD–2008–HA–0168]

Submission for OMB Review; Comment Request

ACTION: Notice.

The Department of Defense has submitted to OMB for clearance, the following proposal for collection of information under the provisions of the Paperwork Reduction Act (44 U.S.C. Chapter 35).

DATES: Consideration will be given to all comments received by August 12, 2009.

Title and OMB Number: Prospective Department of Defense Studies of U.S. Military Forces: The Millennium Cohort Study—OMB Control Number 0720–0029.

Type of Request: Extension.

Number of Respondents: 36,599.

Responses per Respondent: 1.

Annual Responses: 36,599.

Average Burden per Response: 45 minutes.

Annual Burden Hours: 27,450.

Needs and Uses: The Millennium Cohort Study responds to recent recommendations by Congress and by the Institute of Medicine to perform investigations that systematically collect population-based demographic and health data so as to track and evaluate the health of military personnel throughout the course of their careers and after leaving military service.

Affected Public: Individuals or households.

Frequency: On occasion.

Respondent's Obligation: Voluntary.

OMB Desk Officer: Mr. John Kraemer.

Written comments and recommendations on the proposed information collection should be sent to Mr. Kraemer at the Office of Management and Budget, Desk Officer for DoD, Room 10236, New Executive Office Building, Washington, DC 20503.

You may also submit comments, identified by docket number and title, by the following method:

• *Federal eRulemaking Portal: http://www.regulations.gov*. Follow the instructions for submitting comments.

Instructions: All submissions received must include the agency name, docket number and title for this Federal Register document. The general policy for comments and other submissions from members of the public is to make these submissions available for public viewing on the Internet at *http://www.regulations.gov* as they are received without change, including any personal identifiers or contact information.

DOD Clearance Officer: Ms. Patricia Toppings.

Written requests for copies of the information collection proposal should be sent to Ms. Toppings at WHS/ESD/Information Management Division, 1777 North Kent Street, RPN, Suite 11000, Arlington, VA 22209–2133.

Dated: June 30, 2009.

Patricia L. Toppings,

OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. E9–16489 Filed 7–10–09; 8:45 am]

BILLING CODE 5001–06–P

DEPARTMENT OF EDUCATION

Office of Special Education and Rehabilitative Services; Overview Information; Technical Assistance and Dissemination To Improve Services and Results for Children With Disabilities—Model Demonstration Projects on Tiered Approaches for Improving the Writing Proficiency of High School Students; Notice Inviting Applications for New Awards for Fiscal Year (FY) 2009

Catalog of Federal Domestic Assistance (CFDA) Number: 84.326M.

DATES:

Applications Available: July 13, 2009.

Deadline for Transmittal of Applications: August 12, 2009.

Deadline for Intergovernmental Review: August 24, 2009.

Full Text of Announcement

I. Funding Opportunity Description

Purpose of Program: The purpose of the Technical Assistance and Dissemination to Improve Services and Results for Children with Disabilities

program is to promote academic achievement and to improve results for children with disabilities by providing technical assistance (TA), supporting model demonstration projects, disseminating useful information, and implementing activities that are supported by scientifically based research.

Priority: In accordance with 34 CFR 75.105(b)(2)(v), this priority is from allowable activities specified in the statute (see sections 663 and 681(d) of the Individuals with Disabilities Education Act (IDEA), 20 U.S.C. 1400 *et seq.*).

Absolute Priority: For FY 2009 and any subsequent year in which we make awards from the list of unfunded applicants from this competition, this priority is an absolute priority. Under 34 CFR 75.105(c)(3), we consider only applications that meet this priority.

This priority is:

Technical Assistance and Dissemination to Improve Services and Results for Children With Disabilities—Model Demonstration Projects on Tiered Approaches for Improving the Writing Proficiency of High School Students.

Background

Writing skills are critical to success in both college and the workplace. With the inclusion of a writing portion on college entrance exams, such as the Scholastic Assessment Test (SAT), and the writing requirements in high stakes [1] high school graduation exams, there is an increased emphasis on writing for all students in high school. Furthermore, college faculty and employers recognize that writing is a skill that students need to succeed in many postschool settings (Alliance for Excellent Education, 2007). Yet, according to the National Assessment of Educational Progress (NAEP), in 2007, despite overall gains in performance on the eighth- and twelfth-grade NAEP Writing assessment, only 33 percent of eighth-grade students and 24 percent of twelfth-grade students scored at or above the proficient level in writing (Salahu-Din, Persky & Miller, 2008). Students with disabilities scored almost 40 points below the scores of all students who participated in the assessment. The NAEP data and recommendations from policymakers (National Association of State Boards of Education, 2006) indicate the need to identify strategies that can improve writing proficiency among high school students.

Students who have writing difficulties, including those at risk for and with learning disabilities, may benefit from a variety of instructional interventions, especially those that provide authentic writing opportunities, facilitate the development of self-learning strategies, and allow for extensive peer-to-peer interaction (MacArthur & Graham, 1993). Examining methodologies and interventions that have been effective in other educational settings may assist with developing strategies that can improve writing proficiency among high school students.

In an educational context, schoolwide tiered approaches are sometimes used to improve student learning and behavior. Tiered approaches typically use the following evidence-based components: Universal screening, progress monitoring, high-quality core instruction, and instructional interventions at varying levels of intensity based on students' learning needs. Using a tiered approach, educators monitor student progress and make data-based decisions about curriculum, instructional interventions, and student supports (Johnson, Mellard, Fuchs & McKnight, 2006). In tiered approaches, students' responses to instruction are monitored to identify those students in need of more targeted and customized instruction (Fuchs & Fuchs, 2007).

Educators most commonly implement tiered approaches in elementary schools (Deshler & Kovaleski, 2007; Duffy, n.d.; Johnson & Smith, 2008) and typically incorporate evidence-based instructional interventions related to reading, math, or behavior. Tiered approaches in elementary schools show promise for increasing students' achievement in each of these three areas (Burns, 2008; Canter, Klotz, & Cowan, 2008) and may be applied with writing instruction as well (Hessler & Konrad, 2008). Further, there is evidence that tiered approaches may serve as an impetus for educators to examine the referral process for special education services and promote early identification of children at risk for, or with, learning disabilities, particularly, students with specific learning disabilities (Fuchs & Fuchs, 2007; National Research Center on Learning Disabilities, 2004). Practices inherent in the application of tiered approaches, such as the alignment of expected outcomes, teaching strategies, and assessment, along with the improvement of instructional decisionmaking by educators in both regular and special education that is associated with tiered approaches may also offer secondary benefits for students (Cummings, Atkins, Allison, & Cole, 2008). These benefits include reductions in the frequency of challenging behaviors exhibited by students and enhanced academic engagement (Iovannone & Dunlap, 2006; March & Peters, 2002). Additionally, tiered approaches are characterized by collaboration between regular and special educators and teaching is tailored to student needs because instructional approaches are linked to student achievement (Duffy, n.d.).

Less is known about the potential of these approaches for improving outcomes for high school students. Due to the differences between elementary and secondary school settings (*i.e.*, increased student mobility across classes, variation in student schedules, and increased emphasis on academic content), there is a need for additional work on assessing the effectiveness of tiered approaches for specific content areas in high schools. Further, the field is learning that many of the same strategies used at the elementary level, are also effective, or may be effective, at the secondary level (Heartland Area Education Agency 11, 2004). However, there continues to be a need to identify adaptations that need to be made based upon the high school context. Therefore, the Office of Special Education Programs (OSEP) is establishing a priority for Model Demonstration Projects on Tiered Approaches for Improving the Writing Proficiency of High School Students.

Priority

The purpose of this priority is to fund cooperative agreements to support the establishment and operation of three Model Demonstration Projects on Tiered Approaches for Improving the Writing Proficiency of High School Students (Projects) who have writing difficulties, including those at risk for and with learning disabilities. Each project must design, implement, and evaluate a tiered approach in high schools that incorporates evidenced-based components including screening, progress monitoring, core instruction, and instructional interventions at varying levels of intensity based on students' learning needs. The models must have writing as the core instructional component.

To be considered for funding under this absolute priority, applicants must meet the application requirements contained in this priority. All projects funded under this absolute priority also must meet the programmatic and administrative requirements specified in the priority.

[1] ''High stakes testing'' is ''the term used for assessments that determine if a student is retained in a grade or allowed to receive a diploma and graduate'' (Lynch, 2000, p. 216).

Application Requirements. An applicant must include in its application—

(a) A logic model that depicts, at a minimum, the goals, activities, outputs, and outcomes of the proposed project. A logic model communicates how a project will achieve its outcomes and provides a framework for both the formative and summative evaluations of the project; **Note:** The following Web site provides more information on logic models and lists multiple online resources: *http://www.cdc.gov/eval/resources.htm*.

(b) A plan to implement the activities described in the *Project Activities* section of this priority;

(c) A plan, linked to the proposed project's logic model, for a formative evaluation of the proposed project's activities. The plan must describe how the formative evaluation will use clear performance objectives to ensure continuous improvement in the operation of the proposed project, including objective measures of progress in implementing the project and ensuring the quality of products and services;

(d) A description of the proposed model (tiered approach), supporting evidence for the model as a whole, and empirical support of the critical evidence-based components, including the writing instruction and interventions that comprise the model;

(e) The methods to be used for recruiting and selecting high schools if the applicant has not identified schools that are willing to participate in the model demonstrations. Applicants must put into place strategies for recruiting low-performing high schools. If the applicant has identified high schools willing to participate in the model demonstrations, also include a description of the demographics of the student population typically served by the schools, including information about the cultural and linguistic diversity of students. The final site selections must be determined in consultation with the OSEP Project Officer following the kick-off meeting;

(f) A budget for attendance at the following:

(1) A one and one half day kick-off meeting to be held in Washington, DC, within four weeks after receipt of the award and a one day annual planning meeting held in Washington, DC, with the OSEP Project Officer during each subsequent year of the project period.

(2) A three-day Project Directors' Conference in Washington, DC, during each year of the project period; and

(3) Two two-day trips annually to attend Department briefings, Department-sponsored conferences, and other meetings, as requested by OSEP.

Project Activities. To meet the requirements of this priority, each Project, at a minimum, must—

(a) In year one of the project, collaborate with the other Projects funded under this competition to conduct a systematic review of the research on:

(1) Tiered approaches, including tiered writing approaches in high school, and their evidence-based components; and

(2) Writing instruction and interventions for high school students. To the extent possible, build on existing research reviews, such as those on tiered approaches conducted by the OSEP-funded National Research Center on Learning Disabilities (*http://www.nrcld.org*) and use the standards established by the What Works Clearinghouse for identifying evidence-based interventions and practices in the research review (*http://ies.ed.gov/ncee/wwc/*). If it is not possible to use these standards, other rigorous standards must be used. This work must be completed during the first year of the project and result in a comprehensive description of any evidence on the application of tiered approaches in high schools and writing instruction for high school students;

(b) Implement a model at the high school ninth grade level that:

(1) Includes evidence-based components such as universal screening, progress monitoring, and writing instruction and interventions at varying intensity levels; and

(2) May be adapted to address unique characteristics of the school that may affect writing proficiency, such as the cultural and linguistic diversity of the students.

(c) Adopt a staggered implementation design with longitudinal data collection in at least two high schools (high school A and high school B) using the following approach:

(1) Implement the model in one department in high school A in the fall of year two.

(2) Implement the model in high schools A and B in the fall of year three.

(3) Implement the model in high schools A and B in the fall of year four.

(4) Collect data on the writing proficiency of all students who participated in the model as they move through high school even though the projects will only implement the writing intervention in the ninth grade.

(d) Provide initial and ongoing professional development at the model demonstration sites to regular educators, special educators, related services providers, and administrators who are charged with implementing the model. Ensure that there is a process for providing feedback to these personnel on their implementation of the critical components of the model;

(e) Implement an evaluation plan that includes a detailed description of the model and the critical components of the model, a description of the school and district variables required to implement and sustain the model, and the processes for collecting and analyzing specific project and cross-project data related to the:

(1) Effectiveness of the model to improve student writing proficiency.

(2) Fidelity of the implementation of the model and acceptable variations based on the unique characteristics of schools that may affect writing proficiency, such as the cultural and linguistic diversity of students.

(3) Effectiveness of the professional development provided to personnel implementing the model. Common cross-site data to be collected must be determined in consultation with the OSEP Project Officer following the first cross-project meeting.

(4) Effectiveness of the model to inform the special education referral process.

(f) Identify methods for effectively supporting ongoing communication and collaboration among families, students, school staff, and project staff to support the implementation and evaluation of the model;

(g) Document the effects of the model on additional variables identified by the Project such as changes in student engagement, challenging behaviors, and instructional decisionmaking;

(h) Coordinate with the other Projects funded under this competition and the Model Demonstration Coordination Center (MDCC) to determine a cross-project plan for evaluating the impact of the models. The MDCC is a separate center funded by OSEP that is responsible for coordinating implementation and analyzing data to determine the effectiveness of the models. MDCC will develop a data coordination plan, cross-site data collection instruments, and common evaluation questions. MDCC will also synthesize and analyze data, monitor implementation fidelity, ensure data reliability, and foster information dissemination. As part of cross-site coordination, Projects must collect data across common measures as determined by MDCC that may or may not be the same as those proposed by the applicant. Common measures may include observations or data describing the context of schools, classrooms, or

students participating in the project, as well as schools, classrooms, or students who did not participate in the project. The purpose of the data is to provide information on the contexts in which models are implemented and the effectiveness of the models; **Note:** The following Web site provides more information on the project resource commitments necessary for MDCC collaboration, see section entitled, ''Project Resource Commitments'' at: *http://mdcc.sri.com/projectResourceCommitments.aspx*;

(i) Communicate and collaborate on an ongoing basis with OSEP-funded projects, including the National Center on Response to Intervention (*http://www.rti4success.org/*) and the Center on Instruction (*http://www.centeroninstruction.org*) to share information on successful strategies and implementation challenges regarding tiered approaches in high schools;

(j) Develop a high-quality dissemination plan that reaches broad audiences including regular educators, special educators, related services providers, administrators, families, policymakers, and researchers.

The plan must specify how the grantee will collaborate with MDCC and with OSEP's Technical Assistance and Dissemination Network;

(k) Submit to the OSEP Project Officer and the Proposed Product Advisory Board at OSEP's Technical Assistance Coordinating Center (TACC), for approval, a proposal describing the content and purpose of any new product prior to development; and

(l) Maintain ongoing communication with the OSEP Project Officer and the MDCC through monthly phone conversations and e-mail communication.

References

Alliance for Excellent Education, (2007, April). Making writing instruction a priority in America's middle and high schools. Alliance for Excellent Education Policy Brief. Washington, DC. Retrieved March 20, 2008 from *http://www.all4ed.org/files/WritPrior.pdf*.

Burns, M.K. (2008). Response to intervention at the secondary level. *Principal Leadership*, *8*(6), 12–15.

Canter, A., Klotz, M.B., & Cowan, K. (2008). Response to intervention: The future for secondary schools. *Principal Leadership*, *8*(7), 12–15.

Cummings, K.D., Atkins, T., Allison, R. & Cole, C. (2008). Response to intervention: Investigating the new role of special educators. *Teaching Exceptional Children*, *40*(4), 24–31.

Deshler, D. & Kovaleski, J. (2007, December). RTI and secondary education: What are the implications? Conference presentation at the National RTI Summit. Washington, DC.

Duffy, H. (n.d.). Meeting the needs of significantly struggling learners in high school. Retrieved March 20, 2008 from *http://www.betterhighschools.org/docs/NHSC_RTIBrief_08-02-07.pdf*.

Fuchs, D. & Fuchs, L. (2007). A model for implementing responsiveness to intervention. *Teaching Exceptional Children*, *39*(5), 14–20.

Heartland Area Education Agency 11 (2004, April 1). Heartland AEA 11 annual progress report. Retrieved May 7, 2009 from *http://www.aea11.k12.ia.us/downloads/2004apr.pdf*.

Hessler, T. & Konrad, M. (2008). Using curriculum-based measurement to drive IEPs and instruction in written expression. *Teaching Exceptional Children*, *41*(2), 28–37.

Iovannone, R. & Dunlap, G. (2006). Curriculum & behavior problems. *Alaska Education Service Agency Newsletter*. Retrieved March 20, 2008 from *http://www.sesa.org/?view=article&catid=112percent3AFall+2002&id=385percent3ACurriculum+&Behavior_Problems:_Cause_=&Effect?=&Itemid=69&option=com_content*.

Johnson, E., Mellard, D.F., Fuchs, D., & McKnight, M.A. (2006). *Responsiveness to intervention (RTI): How to do it*. Lawrence, KS: National Research Center on Learning Disabilities.

Johnson, E. & Smith, L. (2008). Implementation of response to intervention at middle school. *Teaching Exceptional Children*, *40*(3), 46–52.

Lynch, S. J. (2000). Equity and science education reform. Mahwah, NJ: Lawrence Erlbaum Associates. March, J.K. & Peters, K.H. (2002). Curriculum development and instructional design in the effective school process. *Phi Delta Kappan*, *83*(5), 379–381.

MacArthur, C. & Graham, S. (1993). Integrating strategy instruction and word processing into a process approach to writing instruction. *School Psychology Review*, *22*(4), 671–682.

National Association of State Boards of Education. (2006). Reading at risk: The state response to the crisis in adolescent literacy. Retrieved May 5, 2008 from *http://nasbe.org/index.php/file-repository?func=finishdown&id=439*.

National Research Center on Learning Disabilities. (2004). Executive summary of the NRCLD symposium on responsiveness to intervention [Brochure]. Lawrence, KS: Author.

Salahu-Din, D., Persky, H., and Miller, J. (2008). The nation's report card: Writing 2007 (NCES 2008–468). National Center for Education Statistics, Institute of Education Sciences, U.S. Department of Education, Washington, DC. Retrieved April 6, 2008 from *http://nces.ed.gov/pubsearch/pubsinfo.asp?pubid=2008468*.

Waiver of Proposed Rulemaking: Under the Administrative Procedure Act (APA) (5 U.S.C. 553), the Department generally offers interested parties the opportunity to comment on proposed priorities and requirements. Section 681(d) of IDEA, however, makes the public comment requirements of the APA inapplicable to the priority in this notice.

Program Authority: 20 U.S.C. 1463 and 1481.

Applicable Regulations: The Education Department General Administrative Regulations (EDGAR) in 34 CFR parts 74, 75, 77, 79, 80, 81, 82, 84, 85, 86, 97, 98, and 99.

Note: The regulations in 34 CFR part 79 apply to all applicants except Federally recognized Indian Tribes.

Note: The regulations in 34 CFR part 86 apply to institutions of higher education only.

II. Award Information

Type of Award: Cooperative agreements.

Estimated Available Funds: $1,200,000.

Contingent upon the availability of funds and the quality of applications for the competitions announced in this notice, we may make additional awards in FY 2010 from the lists of unfunded applicants from the groups funded in this competition (See section V.2. Review and Selection Process for more information).

Estimated Average Size of Awards: $400,000.

Maximum Award: We will reject any application that proposes a budget exceeding $400,000 for a single budget period of 12 months. The Assistant Secretary for Special Education and Rehabilitative Services may change the maximum amount through a notice published in the **Federal Register**.

Estimated Number of Awards: 3.

Note: The Department is not bound by any estimates in this notice.

Project Period: Up to 48 months.

III. Eligibility Information

1. *Eligible Applicants:* State educational agencies; local educational agencies (LEAs), including public charter schools that are considered LEAs under State law; institutions of higher education; other public agencies; private nonprofit organizations; outlying areas; freely associated States; Indian Tribes or Tribal organizations; and for-profit organizations.

2. *Cost Sharing or Matching:* This competition does not require cost sharing or matching.

3. *Other: General Requirements*—(a) The projects funded under this competition must make positive efforts to employ and advance in employment

qualified individuals with disabilities (*see* section 606 of IDEA).

(b) Applicants and grant recipients funded under this competition must involve individuals with disabilities or parents of individuals with disabilities ages birth through 26 in planning, implementing, and evaluating the projects (*see* section 682(a)(1)(A) of IDEA).

IV. Application and Submission Information

1. *Address to Request Application Package:* Education Publications Center (ED Pubs), P.O. Box 1398, Jessup, MD 20794–1398. Telephone, toll free: 1–877–433–7827. FAX: (301) 470–1244. If you use a telecommunications device for the deaf (TDD), call, toll free: 1–877–576–7734.

You can contact ED Pubs at its Web site, also: *http://www.ed.gov/pubs/edpubs.html* or at its e-mail address: *edpubs@inet.ed.gov*.

If you request an application package from ED Pubs, be sure to identify this program or competition as follows: CFDA number 84.326M.

Individuals with disabilities can obtain a copy of the application package in an accessible format (*e.g.*, braille, large print, audiotape, or computer diskette) by contacting the person or team listed under *Accessible Format* in section VIII of this notice.

2. *Content and Form of Application Submission:* Requirements concerning the content of an application, together with the forms you must submit, are in the application package for this competition. Page Limit: The application narrative (Part III of the application) is where you, the applicant, address the selection criteria that reviewers use to evaluate your application. You must limit the application narrative to the equivalent of no more than 70 pages, using the following standards:

• A ''page'' is 8.5″ x 11″, on one side only, with 1″ margins at the top, bottom, and both sides.

• Double space (no more than three lines per vertical inch) all text in the application narrative, including titles, headings, footnotes, quotations, references, and captions, as well as all text in charts, tables, figures, and graphs.

• Use a font that is either 12 point or larger or no smaller than 10 pitch (characters per inch).

The page limit does not apply to Part I, the cover sheet; Part II, the budget section, including the narrative budget justification; Part IV, the assurances and certifications; or the one-page abstract, the resumes, the bibliography, the references, or the letters of support. However, the page limit does apply to all of the application narrative section (Part III).

We will reject your application if you exceed the page limit or if you apply other standards and exceed the equivalent of the page limit.

3. *Submission Dates and Times: Applications Available:* July 13, 2009.

Deadline for Transmittal of Applications: August 12, 2009.

Applications for grants under this competition may be submitted electronically using the Electronic Grant Application System (e-Application) accessible through the Department's e-Grants site, or in paper format by mail or hand delivery. For information (including dates and times) about how to submit your application electronically, or in paper format by mail or hand delivery, please refer to section IV. 6. *Other Submission Requirements of this notice.*

We do not consider an application that does not comply with the deadline requirements.

Individuals with disabilities who need an accommodation or auxiliary aid in connection with the application process should contact the person listed under **FOR FURTHER INFORMATION CONTACT** in section VII of this notice. If the Department provides an accommodation or auxiliary aid to an individual with a disability in connection with the application process, the individual's application remains subject to all other requirements and limitations in this notice.

Deadline for Intergovernmental Review: August 24, 2009.

4. *Intergovernmental Review:* This competition is subject to Executive Order 12372 and the regulations in 34 CFR part 79. Information about Intergovernmental Review of Federal Programs under Executive Order 12372 is in the application package for this competition.

5. *Funding Restrictions:* We reference regulations outlining funding restrictions in the Applicable Regulations section of this notice.

6. *Other Submission Requirements:* Applications for grants under this program may be submitted electronically or in paper format by mail or hand delivery.

a. *Electronic Submission of Applications.*

If you choose to submit your application to us electronically, you must use e-Application, accessible through the Department's e-Grants Web site page at: *http://e-grants.ed.gov.*

While completing your electronic application, you will be entering data online that will be saved into a database. You may not e-mail an electronic copy of a grant application to us.

Please note the following:

• Your participation in e-Application is voluntary.

• You must complete the electronic submission of your grant application by 4:30:00 p.m., Washington, DC time, on the application deadline date. E-Application will not accept an application for this competition after 4:30:00 p.m., Washington, DC time, on the application deadline date. Therefore, we strongly recommend that you do not wait until the application deadline date to begin the application process.

• The hours of operation of the e-Grants Web site are 6:00 a.m. Monday until 7:00 p.m. Wednesday; and 6:00 a.m. Thursday until 8:00 p.m. Sunday, Washington, DC time. Please note that, because of maintenance, the system is unavailable between 8:00 p.m. on Sundays and 6:00 a.m. on Mondays, and between 7:00 p.m. on Wednesdays and 6:00 a.m. on Thursdays, Washington, DC time. Any modifications to these hours are posted on the e-Grants Web site.

• You will not receive additional point value because you submit your application in electronic format, nor will we penalize you if you submit your application in paper format.

• You must submit all documents electronically, including all information you typically provide on the following forms: The Application for Federal Assistance (SF 424), the Department of Education Supplemental Information for SF 424, Budget Information—Non-Construction Programs (ED 524), and all necessary assurances and certifications. You must attach any narrative sections of your application as files in a .DOC (document), RTF (rich text), or .PDF (Portable Document) format. If you upload a file type other than the three file types specified in this paragraph or submit a password protected file, we will not review that material.

• Your electronic application must comply with any page limit requirements described in this notice.

• Prior to submitting your electronic application, you may wish to print a copy of it for your records.

• After you electronically submit your application, you will receive an automatic acknowledgment that will include a PR/Award number (an identifying number unique to your application).

• Within three working days after submitting your electronic application, fax a signed copy of the SF 424 to the Application Control Center after following these steps:

(1) Print SF 424 from e-Application.

(2) The applicant's Authorizing Representative must sign this form.

(3) Place the PR/Award number in the upper right hand corner of the hard-copy signature page of the SF 424.

(4) Fax the signed SF 424 to the Application Control Center at (202) 245–6272.

• We may request that you provide us original signatures on other forms at a later date.

Application Deadline Date Extension in Case of System Unavailability: If you are prevented from electronically submitting your application on the application deadline date because e-Application is unavailable, we will grant you an extension of one business day to enable you to transmit your application electronically, by mail, or by hand delivery. We will grant this extension if—

(1) You are a registered user of e-Application and you have initiated an electronic application for this competition; and

(2)(a) E-Application is unavailable for 60 minutes or more between the hours of 8:30 a.m. and 3:30 p.m., Washington, DC time, on the application deadline date; or

(b) E-Application is unavailable for any period of time between 3:30 p.m. and 4:30:00 p.m., Washington, DC time, on the application deadline date.

We must acknowledge and confirm these periods of unavailability before granting you an extension. To request this extension or to confirm our acknowledgment of any system unavailability, you may contact either (1) the person listed elsewhere in this notice under **FOR FURTHER INFORMATION CONTACT** (*see* VII. Agency Contact) or (2) the e-Grants help desk at 1–888–336–8930. If e-Application is unavailable due to technical problems with the system and, therefore, the application deadline is extended, an e-mail will be sent to all registered users who have initiated an e-Application.

Extensions referred to in this section apply only to the unavailability of E-Application. If e-Application is available, and, for any reason, you are unable to submit your application electronically or you do not receive an automatic acknowledgment of your submission, you may submit your application in paper format by mail or hand delivery in accordance with the instructions in this notice.

b. *Submission of Paper Applications by Mail.*

If you submit your application in paper format by mail (through the U.S. Postal Service or a commercial carrier), you must mail the original and two copies of your application, on or before the application deadline date, to the Department at the following address: U.S. Department of Education, Application Control Center, Attention: (CFDA Number 84.326M), LBJ Basement Level 1, 400 Maryland Avenue, SW., Washington, DC 20202–4260.

You must show proof of mailing consisting of one of the following:

(1) A legibly dated U.S. Postal Service postmark.

(2) A legible mail receipt with the date of mailing stamped by the U.S. Postal Service.

(3) A dated shipping label, invoice, or receipt from a commercial carrier.

(4) Any other proof of mailing acceptable to the Secretary of the U.S. Department of Education.

If you mail your application through the U.S. Postal Service, we do not accept either of the following as proof of mailing:

(1) A private metered postmark.

(2) A mail receipt that is not dated by the U.S. Postal Service.

If your application is postmarked after the application deadline date, we will not consider your application.

Note: The U.S. Postal Service does not uniformly provide a dated postmark. Before relying on this method, you should check with your local post office.

c. *Submission of Paper Applications by Hand Delivery.*

If you submit your application in paper format by hand delivery, you (or a courier service) must deliver the original and two copies of your application by hand, on or before the application deadline date, to the Department at the following address: U.S. Department of Education, Application Control Center, Attention: (CFDA Number 84.326M), 550 12th Street, SW., Room 7041, Potomac Center Plaza, Washington, DC 20202–4260.

The Application Control Center accepts hand deliveries daily between 8:00 a.m. and 4:30:00 p.m., Washington, DC time, except Saturdays, Sundays, and Federal holidays.

Note for Mail or Hand Delivery of Paper

Applications:

If you mail or hand deliver your application to the Department—

(1) You must indicate on the envelope and—if not provided by the Department—in Item 11 of the SF 424 the CFDA number, including suffix letter, if any, of the competition under which you are submitting your application; and

(2) The Application Control Center will mail to you a notification of receipt of your grant application. If you do not receive this notification within 15 business days from the application deadline date, you should call the U.S. Department of Education Application Control Center at (202) 245–6288.

V. Application Review Information

1. *Selection Criteria:* The selection criteria for this competition are from 34 CFR 75.210 and are listed in the application package.

2. *Review and Selection Process:* In the past, the Department has had difficulty finding peer reviewers for certain competitions because so many individuals who are eligible to serve as peer reviewers have conflicts of interest. The Standing Panel requirements under IDEA also have placed additional constraints on the availability of reviewers. Therefore, the Department has determined that, for some discretionary grant competitions, applications may be separated into two or more groups and ranked and selected for funding within the specific groups. This procedure will make it easier for the Department to find peer reviewers by ensuring that greater numbers of individuals who are eligible to serve as reviewers for any particular group of applicants will not have conflicts of interest. It also will increase the quality, independence, and fairness of the review process while permitting panel members to review applications under discretionary grant competitions for which they also have submitted applications. However, if the Department decides to select an equal number of applications in each group for funding, this may result in different cut-off points for fundable applications in each group.

VI. Award Administration Information

1. *Award Notices:* If your application is successful, we notify your U.S. Representative and U.S. Senators and send you a Grant Award Notification (GAN). We may notify you informally, also.

If your application is not evaluated or not selected for funding, we notify you.

2. *Administrative and National Policy Requirements:* We identify administrative and national policy requirements in the application package and reference these and other requirements in the *Applicable Regulations* section of this notice.

We reference the regulations outlining the terms and conditions of an award in the *Applicable Regulations* section of this notice and include these and other specific conditions in the GAN. The GAN also incorporates your approved application as part of your binding commitments under the grant.

3. *Reporting:* At the end of your project period, you must submit a final performance report, including financial information, as directed by the Secretary. If you receive a multi-year award, you must submit an annual performance report that provides the most current performance and financial expenditure information as directed by the Secretary under 34 CFR 75.118. The Secretary may also require more frequent performance reports under 34 CFR 75.720(c). For specific requirements on reporting, please go to *http://www.ed.gov/fund/grant/apply/appforms/appforms.html*.

4. *Performance Measures:* Under the Government Performance and Results Act of 1993 (GPRA), the Department has established a set of performance measures, including long-term measures, that are designed to yield information on various aspects of the effectiveness and quality of the Technical Assistance and Dissemination to Improve Services and Results for Children With Disabilities program. These measures focus on the extent to which projects provide high quality products and services, the relevance of project products and services to educational and early intervention policy and practice, and the use of products and services to improve educational and early intervention policy and practice.

Grantees will be required to provide information related to these measures in annual reports to the Department.

Grantees also will be required to report information on their project's performance in annual reports to the Department (34 CFR 75.590).

VII. Agency Contact

FOR FURTHER INFORMATION CONTACT: Corinne Weidenthal, U.S. Department of Education, 400 Maryland Avenue, SW., room 4120, Potomac Center Plaza (PCP), Washington, DC 20202–2550. Telephone: (202) 245–6529.

If you use a TDD, call the Federal Relay Service (FRS), toll free, at 1–800–877–8339.

VIII. Other Information

Accessible Format: Individuals with disabilities can obtain this document and a copy of the application package in an accessible format (*e.g.*, braille, large print, audiotape, or computer diskette) by contacting the Grants and Contracts Services Team, U.S. Department of Education, 400 Maryland Avenue, SW., room 5075, PCP, Washington, DC 20202–2550. Telephone: (202) 245–7363. If you use a TDD, call the FRS, toll free, at 1–800–877–8339.

Electronic Access to This Document: You can view this document, as well as all other documents of this Department published in the **Federal Register**, in text or Adobe Portable Document Format (PDF) on the Internet at the following site: *http://www.ed.gov/news/fedregister*.

To use PDF you must have Adobe Acrobat Reader, which is available free at this site. If you have questions about using PDF, call the U.S. Government Printing Office (GPO), toll free, at 1–888–293–6498; or in the Washington, DC area at (202) 512–1530.

Note: The official version of this document is the document published in the **Federal Register**. Free Internet access to the official edition of the **Federal Register** and the Code of Federal Regulations is available on GPO Access at: *http://www.gpoaccess.gov/nara/index.html*.

Delegation of Authority: The Secretary of Education has delegated authority to Andrew J. Pepin, Executive Administrator for Special Education and Rehabilitative Services to perform the functions of the Assistant Secretary for Special Education and Rehabilitative Services.

Dated: July 8, 2009.

Andrew J. Pepin,

Executive Administrator for Special Education and Rehabilitative Services.

[FR Doc. E9–16549 Filed 7–10–09; 8:45 am]

BILLING CODE 4000–01–P

ELECTION ASSISTANCE COMMISSION

Sunshine Act Notice

AGENCY: U.S. Election Assistance Commission.

ACTION: Notice of Public Meeting and Hearing Agenda (Amended).

DATE AND TIME: Tuesday, July 14, 2009, 1 p.m.–4 p.m. EDT (Meeting and Hearing).

PLACE: U.S. Election Assistance Commission, 1225 New York Ave, NW., Suite 150, Washington, DC 20005 (Metro Stop: Metro Center).

AGENDA: Please note the extended deadlines for oral and written testimony. The Commission will hold a public meeting to consider administrative matters. The Commission will consider re-accreditation of two voting system test laboratories. The Commission will receive a briefing on the Accessible Voting Technology Initiative, with a representative from NIST available to help answer questions. The Commission will hear from members of the public regarding technological solutions for voting systems to ensure that voters with disabilities can vote in a private and independent manner.

Members of the public who wish to speak at the meeting, regarding technological solutions for voting systems that ensure that voters with disabilities can vote in a private and independent manner, may send a request to participate to the EAC by 10 a.m. EDT on Monday, July 13, 2009. Due to time constraints, the EAC can select no more than 6 participants amongst the volunteers who request to participate. The selected volunteers will be allotted 5 minutes each to share their viewpoint. Participants will be selected on a first-come, first-served basis. However, to maximize diversity of input, only one participant per organization or entity will be chosen if necessary. Participants will receive confirmation by 12 p.m. EDT on Monday, July 13, 2009. Those who are not selected to speak may provide written comments. Requests to speak may be sent to the EAC via e-mail at *testimony@eac.gov*, via mail addressed to the U.S. Election Assistance Commission, 1225 New York Avenue, NW., Suite 1100, Washington, DC 20005, or by fax at 202–566–1389. All requests must include a description of what will be said, contact information which will be used to notify the requestor with status of request (phone number on which a message may be left or e-mail), and include the subject/attention line (or on the envelope if by mail): Technology and Disability Access. Please note that these comments will be made available to the public at *http://www.eac.gov*.

Written comments from members of the public, regarding technological solutions for voting systems that ensure that voters with disabilities can vote in a private and independent manner, will also be accepted. This testimony will be included as part of the written record of the hearing, and available on our Web site. Written testimony must be received by 3 p.m. EDT on Monday, July 13, 2009, and should be submitted via e-mail at *testimony@eac.gov,* via mail addressed to the U.S. Election Assistance Commission, 1225 New York Avenue, NW., Suite 1100, Washington, DC 20005, or by fax at 202–566–1389. All correspondence that contains written testimony must have in the subject/attention line (or on the envelope if by mail): Written

Submission for Technology and Disability Access.

Members of the public may observe but not participate in EAC meetings unless this notice provides otherwise. Members of the public may use small electronic audio recording devices to record the proceedings. The use of other recording equipment and cameras requires advance notice to and coordination with the Commission's Communications Office.[1]

This meeting will be open to the public.

PERSON TO CONTACT FOR INFORMATION: Bryan Whitener, Telephone: (202) 566–3100.

Gineen Beach,

Chair, U.S. Election Assistance Commission.

[FR Doc. E9–16634 Filed 7–9–09; 4:15 pm]

BILLING CODE 6820–KF–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Project No. 13452–000]

McGinnis, Inc.; Notice of Preliminary Permit Application Accepted for Filing and Soliciting Comments, Motions To Intervene, and Competing Applications

July 2, 2009.

On April 29, 2009, McGinnis, Inc. filed an application for a preliminary permit, pursuant to section 4(f) of the Federal Power Act, proposing to study the feasibility of the Cannelton Hydrokinetic Project, located on the Ohio River, in Hancock County, Kentucky, and Perry County, Indiana. The sole purpose of a preliminary permit, if issued, is to grant the permit holder priority to file a license application during the permit term. A preliminary permit does not authorize the permit holder to perform any land disturbing activities or otherwise enter upon lands or waters owned by others without the owners' express permission.

The proposed project would consist of: (1) A 100 to 300-foot-long by 20 to 52-foot-wide barge spudded down to the riverbed; (2) 10 6–8-foot-long by 6–8-foot-diameter turbine-generators mounted in line along the side of the barge; (3) one armored, high-voltage cable transmitting the generated power to the existing transmission line located adjacent to the proposed project area; and (4) appurtenant facilities. The proposed project would generate about 1,533 megawatt-hours.

Applicant Contact: Bruce D. McGinnis, Sr., McGinnis, Inc., P. O. Box 534, 502 Second St., Ext., South Point, OH 45680, phone: (740) 377–4391.

FERC Contact: Sergiu Serban, 202–502–6211.

Deadline for filing comments, motions to intervene, competing applications (without notices of intent), or notices of intent to file competing applications: 60 days from the issuance of this notice. Comments, motions to intervene, notices of intent, and competing applications may be filed electronically via the Internet. See 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's Web site under the ''e-Filing'' link. If unable to be filed electronically, documents may be paper-filed. To paper-file, an original and eight copies should be mailed to: Kimberly D. Bose, Secretary, Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426. For more information on how to submit these types of filings please go to the Commission's Web site located at *http://www.ferc.gov/filing-comments.asp.*

More information about this project, including a copy of the application, can be viewed or printed on the ''eLibrary'' link of Commission's Web site at *http://www.ferc.gov/docs-filing/elibrary.asp.* Enter the docket number (P–13452) in the docket number field to access the document. For assistance, call toll-free 1–866–208–3372.

Kimberly D. Bose,

Secretary.

[FR Doc. E9–16441 Filed 7–10–09; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Project No. 2232–566]

Duke Energy Carolinas, LLC; Notice of Application for Amendment of License and Soliciting Comments, Motions To Intervene, and Protests

July 2, 2009.

Take notice that the following hydroelectric application has been filed with the Commission and is available for public inspection:

a. *Application Type:* Non-Project Use of Public Lands and Waters.

b. *Project No.:* 2232–566.

c. *Date Filed:* April 22, 2009.

d. *Applicant:* Duke Energy Carolinas, LLC.

e. *Name of Project:* Catawba-Wateree Project.

f. *Location:* The Catawba-Wateree Project is located in Alexander, Burke, Caldwell, Catawba, Gaston, Iredell, Lincoln, McDowell and Mecklenburg Counties, North Carolina and Chester, Fairfield, Kershaw, Lancaster, and York Counties, South Carolina. This project does not occupy any Federal lands.

g. *Filed Pursuant to:* Federal Power Act, 16 U.S.C. 791a–825r.

h. *Applicant Contact:* Mr. Joe Hall, Lake Management Representative, Duke Energy Carolinas, LLC, P.O. Box 1006, Charlotte, North Carolina 28201–1006, (704) 382–8576.

i. *FERC Contact:* Joy Jones, Telephone 202–502–6760, and e-mail: *joy.jones@ferc.gov.*

j. *Deadline for filing comments, motions to intervene, and protest:* August 02, 2009. All documents (original and eight copies) should be filed with: Secretary, Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426.

The Commission's Rules of Practice and Procedure require all interveners filing documents with the Commission to serve a copy of that document on each person whose name appears on the official service list for the project. Further, if an intervener files comments or documents with the Commission relating to the merits of an issue that may affect the responsibilities of a particular resource agency, they must also serve a copy of the document on that resource agency. A copy of any motion to intervene must also be served upon each representative of the Applicant specified in the particular application.

k. *Description of Request:* Duke Energy Carolinas, LLC requests Commission approval of an agreement that would allow Duke to authorize the Town of Mooresville, North Carolina to construct and operate expanded water intake facilities on, and to withdraw water from, Lake Norman. The existing water intake structure would be expanded by connecting a water line to the existing water intake structure and the existing pumping plant. Approximately 125 feet of water line would be within the project boundary. Additionally, new screens with screen openings that do not exceed 0.25 inch would be installed on the existing intake structure. Intake velocities at the intake structure would not exceed 0.5 feet per second. Under the agreement, the expanded facility would have a gross maximum annual average rate of 18 million gallons per day (MGD), a 6 MGD increase from the current approved withdrawal rate. The water intake and pump facility is located in Iredell County, North Carolina.

[1] View *EAC Regulations Implementing Government in the Sunshine Act.*

l. *Locations of the Application:* A copy of the application is available for inspection and reproduction at the Commission's Public Reference Room, located at 888 First Street, NE., Room 2A, Washington, DC 20426, or by calling (202) 502–8371. This filing may also be viewed on the Commission's Web site at *http://www.ferc.gov* using the ''eLibrary'' link. Enter the docket number excluding the last three digits in the docket number field to access the document. You may also register online at *http://www.ferc.gov/docs-filing/esubscription.asp* to be notified via e-mail of new filings and issuances related to this or other pending projects. For assistance, call 1–866–208–3676 or e-mail *FERCOnlineSupport@ferc.gov,* for TTY, call (202) 502–8659. A copy is also available for inspection and reproduction at the address in item (h) above.

m. Individuals desiring to be included on the Commission's mailing list should so indicate by writing to the Secretary of the Commission.

n. *Comments, Protests, or Motions to Intervene:* Anyone may submit comments, a protest, or a motion to intervene in accordance with the requirements of Rules of Practice and Procedure, 18 CFR 385.210, .211, .214. In determining the appropriate action to take, the Commission will consider all protests or other comments filed, but only those who file a motion to intervene in accordance with the Commission's Rules may become a party to the proceeding. Any comments, protests, or motions to intervene must be received on or before the specified comment date for the particular application.

o. Any filings must bear in all capital letters the title ''COMMENTS'', ''PROTEST'', or ''MOTION TO INTERVENE'', as applicable, and the Project Number of the particular application to which the filing refers.

p. *Agency Comments:* Federal, State, and local agencies are invited to file comments on the described application. A copy of the application may be obtained by agencies directly from the Applicant. If an agency does not file comments within the time specified for filing comments, it will be presumed to have no comments. One copy of an agency's comments must also be sent to the Applicant's representatives.

q. Comments, protests and interventions may be filed electronically via the Internet in lieu of paper. See, 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's Web site at *http://www.ferc.gov* under the ''e-Filing'' link.

Kimberly D. Bose,

Secretary.

[FR Doc. E9–16430 Filed 7–10–09; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Project No. 12924–001; Project No. 12922–001; Project No. 12919–001; Project No. 12935–001]

Newton Bend, FFP Project 33, LLC; Milliken Bend, FFP Project 35, LLC; Cat Island, FFP Project 36, LLC; Arsenault Island, FFP Project 56, LLC; Notice of Intent To File License Application, Filing of Pre-Application Document, and Approving Use of the Traditional Licensing Process Procedures

July 2, 2009.

a. *Type of Filing:* Notice of Intent to File License Application and Request to Use the Traditional Licensing Process (TLP).

b. *Project Nos.:* P–12924, P–12922, P–12919, and P–12935.

c. *Dated Filed:* January 15, 2009 (P–12924, P–12922, and P–12919) and June 1, 2009 (P–12935).

d. *Submitted By:* Free Flow Power Corporation and the subsidiary limited liability corporations (listed above and collectively referred to below as ''Free Flow Power'').

e. *Name of Projects:* Free Flow Power Mississippi River TLP Projects (Newton Bend, Milliken Bend, Cat Island, and Arsenault Island).

f. *Locations:* On the Mississippi River, in Warren (P–12924 and P–12922), Claiborne (P–12924) and Issaquena (P–12919) Counties in Mississippi; Tensas (P–12924), Madison (P–12924 and P–12922), and East Carroll (P–12922 and 12919) Counties in Louisiana; St. Clair County (P–12935), Illinois; and St. Louis City County (P–12935), Missouri. No federal lands are occupied by the project works or located within the project boundary.

g. *Filed Pursuant to:* 18 CFR 5.3 of the Commission's regulations.

h. *Potential Applicant Contact:* Ms. Ramya Swaminathan, Vice President, Free Flow Power, 33 Commercial Street, Gloucester, MA 01930, (978) 226–1531, *rswaminathan@free-flow-power.com.*

i. *FERC Contact:* Stephen Bowler at (202) 502–6861 or *stephen.bowler@ferc.gov* and Sarah Florentino at (202) 502–6863 or *sarah.florentino@ferc.gov.*

j. On January 15, 2009, Free Flow Power filed a Notice of Intent (NOI) to file license applications for original licenses and a Pre-Application Document (PAD) for the 55 hydrokinetic projects proposed for locations in the Mississippi River from St. Louis, Missouri, to New Orleans, Louisiana. They also requested the use of the Traditional Licensing Process (TLP) for 51 of the 55 proposed sites, later changed to 48 of 55 sites. FERC Project Nos. 12924, 12922, and 12919 were part of the January 15, 2009 TLP request, but the newspapers published in the counties in which the projects would be located did not publish the notices. By letter filed on June 1, 2009, Free Flow Power added Project No. 12935 to the list of proposed sites for which the TLP was requested. On May 21, 2009, Free Flow Power filed records of notices published in local newspapers near the four sites between April 1, 2009, and April 8, 2009. No comments were filed in response to the notices.

k. With this notice, we are initiating informal consultation with: (a) The U.S. Fish and Wildlife Service under section 7 of the Endangered Species Act and the joint agency regulations thereunder at 50 CFR, Part 402; (b) NOAA Fisheries under section 305(b) of the Magnuson-Stevens Fishery Conservation and Management Act and implementing regulations at 50 CFR 600.920; and (c) the State Historic Preservation Officers of Illinois, Louisiana, Mississippi, and Missouri, as required by section 106, National Historical Preservation Act, and the implementing regulations of the Advisory Council on Historic Preservation at 36 CFR 800.2.

l. With this notice, we are designating Free Flow Power Corporation as the Commission's non-federal representative for carrying out informal consultation, pursuant to section 106 of the National Historic Preservation Act.

m. Free Flow Power Corporation filed a PAD, including a proposed process plan and schedule, with the Commission, pursuant to 18 CFR 5.6 of the Commission's regulations.

n. A copy of the PAD is available for review at the Commission in the Public Reference Room or may be viewed on the Commission's Web site (*http://www.ferc.gov*), using the ''eLibrary'' link. Enter the docket number, excluding the last three digits in the docket number field to access the document. For assistance, contact FERC Online Support at *FERCONlineSupport@ferc.gov* or toll free at 1–866–208–3676, of for TTY, (202) 502–8659. A copy is also available for inspection and reproduction at the address in paragraph h.

Register online at *http://ferc.gov/esubscribenow.htm* to be notified via e-mail of new filing and issuances related to this or other pending projects. For assistance, contact FERC Online Support.

Kimberly D. Bose,

Secretary.

[FR Doc. E9–16438 Filed 7–10–09; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Project No. 13451–000]

McGinnis, Inc.; Notice of Preliminary Permit Application Accepted for Filing and Soliciting Comments, Motions To Intervene, and Competing Applications

July 2, 2009.

On April 29, 2009, McGinnis, Inc. filed an application for a preliminary permit, pursuant to section 4(f) of the Federal Power Act, proposing to study the feasibility of the Greenup Hydrokinetic Project, located on the Ohio River, in Greenup County, Kentucky, and Scioto County, Ohio. The sole purpose of a preliminary permit, if issued, is to grant the permit holder priority to file a license application during the permit term. A preliminary permit does not authorize the permit holder to perform any land disturbing activities or otherwise enter upon lands or waters owned by others without the owners' express permission.

The proposed project would consist of: (1) A 100 to 300-foot-long by 20 to 52-foot-wide barge spudded down to the riverbed; (2) 10 6–8-foot-long by 6–8-foot-diameter turbine-generators mounted in line along the side of the barge; (3) one armored, high-voltage cable transmitting the generated power to the existing transmission line located adjacent to the proposed project area; and (4) appurtenant facilities. The proposed project would generate about 1,533 megawatt-hours.

Applicant Contact: Bruce D. McGinnis, Sr., McGinnis, Inc., P.O. Box 534, 502 Second St. Ext., South Point, OH 45680, phone: (740) 377–4391.

FERC Contact: Sergiu Serban, 202–502–6211.

Deadline for filing comments, motions to intervene, competing applications (without notices of intent), or notices of intent to file competing applications: 60 days from the issuance of this notice. Comments, motions to intervene, notices of intent, and competing applications may be filed electronically via the Internet. See 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's Web site under the ''e-Filing'' link. If unable to be filed electronically, documents may be paper-filed. To paper-file, an original and eight copies should be mailed to: Kimberly D. Bose, Secretary, Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426. For more information on how to submit these types of filings please go to the Commission's Web site located at *http://www.ferc.gov/filing-comments.asp.*

More information about this project, including a copy of the application, can be viewed or printed on the ''eLibrary'' link of Commission's Web site at *http://www.ferc.gov/docs-filing/elibrary.asp.* Enter the docket number (P–13451) in the docket number field to access the document. For assistance, call toll-free 1–866–208–3372.

Kimberly D. Bose,

Secretary.

[FR Doc. E9–16440 Filed 7–10–09; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Project No. 13123–002]

Eagle Crest Energy Company; Notice of Application Tendered for Filing With the Commission and Soliciting Additional Study Requests

July 7, 2009.

Take notice that the following hydroelectric application has been filed with the Commission and is available for public inspection.

a. *Type of Application:* Major License.

b. *Project No.:* P–13123–002.

c. *Date filed:* June 23, 2009.

d. *Applicant:* Eagle Crest Energy Company.

e. *Name of Project:* Eagle Mountain Pumped Storage Project.

f. *Location:* The Project would be located in two depleted mining pits in the Eagle Mountain Mine in Riverside County, California, near the Town of Desert Center, California, and would occupy Federal lands administered by the U.S. Bureau of Land Management and private lands owned by Kaiser Eagle Mountain, LLC.

g. *Filed Pursuant to:* Federal Power Act 16 U.S.C. 791(a)–825(r).

h. *Applicant Contact:* Stephen Lowe, One El Paseo West Building, Suite 204, 74–199 El Paseo Drive, Palm Desert, CA 92260.

i. *FERC Contact:* Kim A. Nguyen, 888 First Street, NE., Room 61–01, Washington, DC 20426, 202–502–6105, *Kim.nguyen@ferc.gov*.

j. *Cooperating agencies:* Federal, State, local, and tribal agencies with jurisdiction and/or special expertise with respect to environmental issues that wish to cooperate in the preparation of the environmental document should follow the instructions for filing such requests described in item l below. Cooperating agencies should note the Commission's policy that agencies that cooperate in the preparation of the environmental document cannot also intervene. *See,* 94 FERC ¶ 61,076 (2001).

k. Pursuant to § 4.32(b)(7) of 18 CFR of the Commission's regulations, if any resource agency, Indian Tribe, or person believes that an additional scientific study should be conducted in order to form an adequate factual basis for a complete analysis of the application on its merit, the resource agency, Indian Tribe, or person must file a request for a study with the Commission not later than 60 days from the date of filing of the application, and serve a copy of the request on the applicant.

l. *Deadline for filing additional study requests and requests for cooperating agency status:* August 21, 2009. The deadline for the applicant's response to any such request is 30 days after the filing of the request.

All documents (original and eight copies) should be filed with: Kimberly D. Bose, Secretary, Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426.

Additional study requests and requests for cooperating agency status may be filed electronically via the Internet in lieu of paper. The Commission strongly encourages electronic filings. See 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's Web site (*http://www.ferc.gov/docs-filing/ferconline.asp*) under the ''e-filing'' link. For a simpler method of submitting text only comments, click on ''Quick Comment.''

m. The application has not been accepted for filing and is not ready for environmental analysis at this time.

n. *The project would consist of:* (1) An 191-acre upper reservoir impounded by two diversion dams with a total storage capacity of 20,000 acre-feet; (2) an 163-acre lower reservoir with a total storage capacity of 21,900 acre-feet; (3) a 29-foot-diameter by 4,000-foot-long low pressure upper tunnel; (4) a surge tank with a 33-foot-diameter by 1,348-foot-long tunnel shaft; (5) a 29-foot-diameter by 1,560-foot-long high pressure lower tunnel; (6) a 33-foot-diameter by 6,835-

foot-long tailrace tunnel; (7) a 72-foot-wide, 130-foot-high, and 360-foot-long underground powerhouse; (8) four reversible pump-turbine units at 325 megawatts each, for a total installed capacity of 1,300 megawatts; (9) a 28-foot-wide, 28-foot-high, by 6,625-foot-long access tunnel to the underground powerhouse; (10) a water supply pipeline ranging from 12-to 24-inch-diameter totaling 15.3 miles; (11) a 13.5-mile-long, 500-kilovolt transmission line connecting to a new Interconnection Collector Substation; and (12) appurtenant facilities. The average annual generation is estimated to be 22.2 gigawatt-hours.

o. A copy of the application is available for review at the Commission in the Public Reference Room or may be viewed on the Commission's Web site at *http://www.ferc.gov* using the ''eLibrary'' link. Enter the docket number excluding the last three digits in the docket number field to access the document. For assistance, contact FERC Online Support at *FERCOnlineSupport@ferc.gov* or toll-free at 1–866–208–3676, or for TTY, (202) 502–8659. A copy is also available for inspection and reproduction at the address in item h above.

You may also register online at *http://www.ferc.gov/docs-filing/esubscription.asp* to be notified via e-mail of new filings and issuances related to this or other pending projects. For assistance, contact FERC Online Support.

p. With this notice, we are initiating consultation with the California State Historic Preservation Officer (SHPO), as required by 106, National Historic Preservation Act, and the regulations of the Advisory Council on Historic Preservation, 36, CFR, at 800.4.

q. *Procedural schedule:* The application will be processed according to the following Hydro Licensing Schedule. Revisions to the schedule will be made as appropriate.

Study Requests, Deficiency/Additional Information Letter (if needed)	July 2009.
Issue Acceptance Letter	November 2009.
Notice that Application is Ready for Environmental Analysis	November 2009.
Agency Comments, Terms, and Conditions	January 2010.
Applicant Reply Comments	March 2010.
Notice of the Availability of the Draft EIS	June 2010.
Notice of the Availability of the Final EIS	November 2010.

Kimberly D. Bose,

Secretary.

[FR Doc. E9–16561 Filed 7–10–09; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Project No. 13449–000]

McGinnis, Inc.; Notice of Preliminary Permit Application Accepted for Filing and Soliciting Comments, Motions To Intervene, and Competing Applications

July 6, 2009.

On April 29, 2009, McGinnis, Inc. filed an application for a preliminary permit, pursuant to section 4(f) of the Federal Power Act, proposing to study the feasibility of the Markland Hydrokinetic Project, located on the Ohio River, in Gallatin County, Kentucky, and Switzerland County, Indiana. The sole purpose of a preliminary permit, if issued, is to grant the permit holder priority to file a license application during the permit term. A preliminary permit does not authorize the permit holder to perform any land disturbing activities or otherwise enter upon lands or waters owned by others without the owners' express permission.

The proposed project would consist of: (1) A 100 to 300-foot-long by 20 to 52-foot-wide barge spudded down to the riverbed; (2) 10 6–8-foot-long by 6–8-foot-diameter turbine-generators mounted in line along the side of the barge; (3) one armored, high-voltage cable transmitting the generated power to the existing transmission line located adjacent to the proposed project area; and (4) appurtenant facilities. The proposed project would generate about 1,533 megawatt-hours.

Applicant Contact: Bruce D. McGinnis, Sr., McGinnis, Inc., P.O. Box 534, 502 Second St. Ext., South Point, OH 45680, phone: (740) 377–4391.

FERC Contact: Sergiu Serban, 202–502–6211.

Deadline for filing comments, motions to intervene, competing applications (without notices of intent), or notices of intent to file competing applications: 60 days from the issuance of this notice. Comments, motions to intervene, notices of intent, and competing applications may be filed electronically via the Internet. See 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's Web site under the ''e-Filing'' link. If unable to be filed electronically, documents may be paper-filed. To paper-file, an original and eight copies should be mailed to: Kimberly D. Bose, Secretary, Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426. For more information on how to submit these types of filings please go to the Commission's Web site located at *http://www.ferc.gov/filing-comments.asp.*

More information about this project, including a copy of the application, can be viewed or printed on the ''eLibrary'' link of Commission's Web site at *http://www.ferc.gov/docs-filing/elibrary.asp.* Enter the docket number (P–13449) in the docket number field to access the document. For assistance, call toll-free 1–866–208–3372.

Kimberly D. Bose,

Secretary.

[FR Doc. E9–16446 Filed 7–10–09; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Project No. 485–063]

Georgia Power Company; Notice of Intent To File License Application, Filing of Pre-Application Document, Commencement of Licensing Proceeding, and Scoping; Request for Comments on the Pad and Scoping Document, and Identification of Issues and Associated Study Requests

July 6, 2009.

a. *Type of Filing:* Notice of Intent to File License Application for a New License and Commencing Licensing Proceeding.

b. *Project No.:* 485–063.

c. *Dated Filed:* May 6, 2009.

d. *Submitted By:* Georgia Power Company.

e. *Name of Project:* Bartletts Ferry Hydroelectric Project.

f. *Location:* On the Chattahoochee River in Harris County, Georgia and Lee and Chambers counties, Alabama. The project does not occupy any federal lands.

g. *Filed Pursuant to:* 18 CFR Part 5 of the Commission's Regulations.

h. *Potential Applicant Contact:* Charles H. Huling P.E., Vice President, Georgia Power Company, Environmental Affairs, 241 Ralph McGill Boulevard, NE., BIN 10221, Atlanta, GA 30308–3374. Attn. George A. Martin.

i. *FERC Contact:* Janet Hutzel at (202) 502–8675, or e-mail at *janet.hutzel@ferc.gov.*

j. *Cooperating agencies:* Federal, state, local, and tribal agencies with jurisdiction and/or special expertise with respect to environmental issues that wish to cooperate in the preparation of the environmental document should follow the instructions for filing such requests described in item o below. Cooperating agencies should note the Commission's policy that agencies that cooperate in the preparation of the environmental document cannot also intervene. *See,* 94 FERC ¶ 61,076 (2001).

k. With this notice, we are initiating informal consultation with: (a) The U.S. Fish and Wildlife Service and/or NOAA Fisheries under section 7 of the Endangered Species Act and the joint agency regulations thereunder at 50 CFR, Part 402, and (b) the Alabama and Georgia State Historic Preservation Officers, as required by section 106, National Historical Preservation Act, and the implementing regulations of the Advisory Council on Historic Preservation at 36 CFR 800.2.

l. With this notice, we are designating Georgia Power Company as the Commission's non-federal representative for carrying out informal consultation, pursuant to section 7 of the Endangered Species Act and section 106 of the National Historic Preservation Act.

m. Georgia Power Company filed a Pre-Application Document (PAD; including a proposed process plan and schedule) with the Commission, pursuant to 18 CFR 5.6 of the Commission's regulations.

n. A copy of the PAD is available for review at the Commission in the Public Reference Room or may be viewed on the Commission's website (*http://www.ferc.gov*), using the ''eLibrary'' link. Enter the docket number, excluding the last three digits in the docket number field to access the document. For assistance, contact FERC Online Support at *FERCONlineSupport@ferc.gov,* or toll free at 1–866–208–3676, or for TTY, (202) 502–8659. A copy is also available for inspection and reproduction at the address in paragraph h.

Register online at *http://www.ferc.gov/docs-filing/esubscription.asp* to be notified via e-mail of new filings and issuances related to this or other pending projects. For assistance, contact FERC Online Support.

o. With this notice, we are soliciting comments on the PAD and Scoping Document 1 (SD1), as well as study requests. All comments on the PAD and SD1, and study requests should be sent to the address above in paragraph h. In addition, all comments on the PAD and SD1, study requests, requests for cooperating agency status, and all communications to and from Commission staff related to the merits of the potential application (original and eight copies) must be filed with the Commission at the following address: Kimberly D. Bose, Secretary, Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426. All filings with the Commission must include on the first page the project name (Bartletts Ferry Hydroelectric Project) and the project number (P–485–063), and bear the heading ''Comments on Pre-Application Document,'' ''Study Requests,'' ''Comments on Scoping Document 1,'' ''Request for Cooperating Agency Status,'' or ''Communications to and from Commission Staff.'' Any individual or entity interested in submitting study requests, commenting on the PAD or SD1, and any agency requesting cooperating status must do so by September 4, 2009.

Comments on the PAD and SD1, study requests, requests for cooperating agency status, and other permissible forms of communications with the Commission may be filed electronically via the Internet in lieu of paper. The Commission strongly encourages electronic filings. See 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's Web site (*http://www.ferc.gov/docs-filing/ferconline.asp*) under the ''e-filing'' link. For a simpler method of submitting text only comments, click on ''Quick Comment.''

p. Although our current intent is to prepare an environmental assessment (EA), there is the possibility that an Environmental Impact Statement (EIS) will be required. Nevertheless, this meeting will satisfy the NEPA scoping requirements, irrespective of whether an EA or EIS is issued by the Commission.

Scoping Meetings

Commission staff will hold scoping meetings in the vicinity of the project at the times and places noted below. The daytime meetings will focus on resource agency, Indian tribes, and non-governmental organization concerns, while the evening meetings are primarily for receiving input from the public. We invite all interested individuals, organizations, and agencies to attend any of the meetings, and to assist staff in identifying particular study needs, as well as the scope of environmental issues to be addressed in the environmental document. The times and locations of these meetings are as follows:

August 4, 2009, Daytime Scoping Meeting

Date: Tuesday, August 4, 2009.
Time: 1 p.m. EST.
Location: City of Valley, Alabama's Community Center, 130 Sportsplex Drive, Valley, Alabama 36854.

August 4, 2009, Evening Scoping Meeting

Date: Tuesday, August 4, 2009.
Time: 6 p.m. EST.
Location: City of Valley, Alabama's Community Center, 130 Sportsplex Drive, Valley, Alabama 36854.

August 6, 2009, Daytime Scoping Meeting

Date: Thursday, August 6, 2009.
Time: 1 p.m. EST.
Location: Old Mountain Hill Schoolhouse, 47 Mountain Hill Road, Fortson, Georgia 31808.

August 6, 2009, Evening Scoping Meeting

Date: Thursday, August 6, 2009.
Time: 6 p.m. EST.
Location: Old Mountain Hill Schoolhouse, 47 Mountain Hill Road, Fortson, Georgia 31808.

Scoping Document 1 (SD1), which outlines the subject areas to be addressed in the environmental document, was mailed to the individuals and entities on the Commission's mailing list. Copies of SD1 will be available at the scoping meetings, or may be viewed on the Web at *http://www.ferc.gov,* using the ''eLibrary'' link. Follow the directions for accessing information in paragraph n. Based on all oral and written comments, a Scoping Document 2 (SD2) may be issued. SD2 may include a revised process plan and schedule, as well as a list of issues, identified through the scoping process.

Site Visit

Georgia Power Company and Commission staff will conduct a site visit of the project facilities on Wednesday, August 5, 2009, starting at 10:30 a.m. EST. The site visit will entail touring the project dam and powerhouse. At 1 p.m. EST, a tour of Lake Harding will start from the project's powerhouse. Anyone interested in visiting the project

facilities and/or touring Lake Harding must send an e-mail to Bartletts Ferry Relicensing, at *bfrelice@southerco.com,* by July 24, 2009. Please indicate if you want to visit the project facilities, tour Lake Harding, or both. Participants of the tours must provide identification, sign a liability waiver, and wear appropriate clothing and closed toed shoes. If any participant attending any part of the sites visit is disabled or has special needs, please e-mail Bartletts Ferry Relicensing, at *bfrelice@southerco.com.*

Meeting Objectives

At the scoping meetings, staff will: (1) Initiate scoping of the issues; (2) review and discuss existing conditions and resource management objectives; (3) review and discuss existing information and identify preliminary information and study needs; (4) review and discuss the process plan and schedule for pre-filing activity that incorporates the time frames provided for in Part 5 of the Commission's regulations and, to the extent possible, maximizes coordination of federal, state, and tribal permitting and certification processes; and (5) discuss the appropriateness of any federal or state agency or Indian tribe acting as a cooperating agency for development of an environmental document.

Meeting participants should come prepared to discuss their issues and/or concerns. Please review the PAD in preparation for the scoping meetings. Directions on how to obtain a copy of the PAD and SD1 are included in item n. of this notice.

Meeting Procedures

The meetings will be recorded by a stenographer and will become part of the formal record of the Commission proceeding on the project.

Kimberly D. Bose,

Secretary.

[FR Doc. E9–16444 Filed 7–10–09; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Project No. 2165–029]

Alabama Power Company; Notice of Application for Amendment of License and Soliciting Comments, Motions To Intervene, and Protests

July 2, 2009.

a. *Type of Application:* Non-project use of project lands and waters.

b. *Project Number:* 2165–029.

c. *Date Filed:* June 5, 2009.

d. *Applicant:* Alabama Power Company.

e. *Name of Project:* Warrior River Hydroelectric Project.

f. *Location:* The project is located on Sipsley Fork and the Black Warrior River in Cullman, Tuscaloosa, Walker, and Winston Counties, Alabama. The proposed action would occur at the Lewis Smith Development in Cullman County.

g. *Filed Pursuant to:* Federal Power Act, 16 U.S.C. 791(a), 825(r) and 799 and 801.

h. *Applicant Contact:* Mr. Jason Powers, Alabama Power Company, 600 18th Street North, Birmingham, Alabama 35203, telephone: (205) 257–4070.

i. *FERC Contact:* Any questions on this notice should be addressed to Christopher Yeakel at (202) 502–8132, or e-mail address: *christopher.yeakel@ferc.gov.*

j. *Deadline for filing comments and or motions:* August 3, 2009.

k. *Description of Request:* Alabama Power Company proposes to permit Mr. Lynn Layton to replace one existing, covered, 10-slip boat dock with three covered boat docks, each with 10 slips at Cushman's Marina, located on the Warrior River Project. Each dock would consist of: (1) A 50-foot-long ramp; (2) an equalizing platform; (3) a 78-foot-long central walkway; and (4) ten 12-foot-wide by 28-foot-long slips. Navigational lighting would be installed on each dock. No fuel-dispensing or sewage-pumping facilities are proposed. The docks would be available for rental by the general public. The licensee also proposes to allow the removal of an existing building at the site, and the construction of a new patio within the project boundary.

l. Locations of the Application: A copy of the application is available for inspection and reproduction at the Commission's Public Reference Room, located at 888 First Street, NE., Room 2A, Washington, DC 20426, or by calling (202) 502–8371. This filing may also be viewed on the Commission's Web site at *http://www.ferc.gov* using the ''eLibrary'' link. Enter the docket number excluding the last three digits in the docket number field (p-2165) to access the document. You may also register online at *http://www.ferc.gov/docs-filing/esubscription.asp* to be notified via e-mail of new filings and issuances related to this or other pending projects. For assistance, call 1–866–208–3372 or e-mail *FERCOnlineSupport@ferc.gov,* for TTY, call (202) 502–8659. A copy is also available for inspection and reproduction at the address in item (h) above.

m. Individuals desiring to be included on the Commission's mailing list should so indicate by writing to the Secretary of the Commission.

n. *Comments, Protests, or Motions to Intervene*—Anyone may submit comments, a protest, or a motion to intervene in accordance with the requirements of Rules of Practice and Procedure, 18 CFR 385.210, .211, .214. In determining the appropriate action to take, the Commission will consider all protests or other comments filed, but only those who file a motion to intervene in accordance with the Commission's Rules may become a party to the proceeding. Any comments, protests, or motions to intervene must be received on or before the specified comment date for the particular application.

o. *Filing and Service of Responsive Documents*—Any filings must bear in all capital letters the title ''COMMENTS'', ''RECOMMENDATIONS FOR TERMS AND CONDITIONS'', ''PROTEST'', OR ''MOTION TO INTERVENE'', as applicable, and the Project Number of the particular application to which the filing refers (P–2165–029). All documents (original and eight copies) should be filed with: The Secretary, Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426. A copy of any motion to intervene must also be served upon each representative of the Applicant specified in the particular application.

p. *Agency Comments*—Federal, state, and local agencies are invited to file comments on the described application. A copy of the application may be obtained by agencies directly from the Applicant. If an agency does not file comments within the time specified for filing comments, it will be presumed to have no comments. One copy of an agency's comments must also be sent to the Applicant's representatives.

q. Comments, protests and interventions may be filed electronically via the Internet in lieu of paper. See 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's Web site at *http://www.ferc.gov* under the ''e-Filing'' link.

Kimberly D. Bose,

Secretary.

[FR Doc. E9–16442 Filed 7–10–09; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Project No. 13450–000]

McGinnis, Inc.; Notice of Preliminary Permit Application Accepted for Filing and Soliciting Comments, Motions To Intervene, and Competing Applications

July 2, 2009.

On April 29, 2009, McGinnis, Inc. filed an application for a preliminary permit, pursuant to section 4(f) of the Federal Power Act, proposing to study the feasibility of the John T. Myers Hydrokinetic Project, located on the Ohio River, in Union County, Kentucky, and Posey County, Indiana. The sole purpose of a preliminary permit, if issued, is to grant the permit holder priority to file a license application during the permit term. A preliminary permit does not authorize the permit holder to perform any land disturbing activities or otherwise enter upon lands or waters owned by others without the owners' express permission.

The proposed project would consist of: (1) A 100 to 300-foot-long by 20 to 52-foot-wide barge spudded down to the riverbed; (2) 10 6-8-foot-long by 6-8-foot-diameter turbine-generators mounted in line along the side of the barge; (3) one armored, high-voltage cable transmitting the generated power to the existing transmission line located adjacent to the proposed project area; and (4) appurtenant facilities. The proposed project would generate about 1,533 megawatt-hours.

Applicant Contact: Bruce D. McGinnis, Sr., McGinnis, Inc., P.O. Box 534, 502 Second St. Ext., South Point, OH 45680, phone: (740) 377–4391.

FERC Contact: Sergiu Serban, 202–502–6211.

Deadline for filing comments, motions to intervene, competing applications (without notices of intent), or notices of intent to file competing applications: 60 days from the issuance of this notice. Comments, motions to intervene, notices of intent, and competing applications may be filed electronically via the Internet. See 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's Web site under the ''e-Filing'' link. If unable to be filed electronically, documents may be paper-filed. To paper-file, an original and eight copies should be mailed to: Kimberly D. Bose, Secretary, Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426. For more information on how to submit these types of filings please go to the Commission's Web site located at *http://www.ferc.gov/filing-comments.asp.*

More information about this project, including a copy of the application, can be viewed or printed on the ''eLibrary'' link of Commission's Web site at *http://www.ferc.gov/docs-filing/elibrary.asp.* Enter the docket number (P–13450) in the docket number field to access the document. For assistance, call toll-free 1–866–208–3372.

Kimberly D. Bose,

Secretary.

[FR Doc. E9–16439 Filed 7–10–09; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. OR09–16–000]

Tesoro Refining and Marketing Company Complainant v. SFPP L.P., Respondent; Notice of Complaint

July 2, 2009.

Take notice that on June 30, 2009, Tesoro Refining and Marketing Company (Tesoro) filed a formal complaint against SFPP L.P. (SFPP) pursuant to Rule 206 of the Rules of Practice and Procedure of the Federal Energy Regulatory Commission, 18 CFR 385.206; the Procedural Rules Applicable to Oil Pipeline Proceedings, 18 CFR 343.2; sections 1(5), 8, 9, 13, 15 and 16 of the Interstate Commerce Act (ICA), 49 U.S.C. App. §§ 1(5), 8, 9, 13, 15 and 16 (1984) and section 1803 of the Energy Policy Act of 1992 (EPAct).

Tesoro alleges that SFPP has overstated its cost of service in the 2007 and 2008 Form 6 filed with the Commission. Tesoro requests that the Commission determine that the cost of service methodology employed by SFPP L.P. in the 2007 and 2008 From 6s improperly characterize SFPP's cost of service, resulting in unjust and unreasonable rates, thereby violating sections 1(4) and 1(5) of the ICA and section 343.2(c)(1) of the Commission's regulations.

Tesoro certifies the copies of the complaint were served on the contacts for SFPP as listed on the Commission's list of Corporate Officials.

Any person desiring to intervene or to protest this filing must file in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211, 385.214). Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a notice of intervention or motion to intervene, as appropriate. The Respondent's answer and all interventions or protests must be filed on or before the comment date. The Respondent's answer, motions to intervene, and protests must be served on the Complainants.

The Commission encourages electronic submission of protests and interventions in lieu of paper using the ''eFiling'' link at *http://www.ferc.gov.* Persons unable to file electronically should submit an original and 14 copies of the protest or intervention to the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426.

This filing is accessible on-line at *http://www.ferc.gov,* using the ''eLibrary'' link and is available for review in the Commission's Public Reference Room in Washington, DC. There is an ''eSubscription'' link on the Web site that enables subscribers to receive e-mail notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please e-mail *FERCOnlineSupport@ferc.gov,* or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Comment Date: 5 p.m. Eastern Time on July 20, 2009.

Kimberly D. Bose,

Secretary.

[FR Doc. E9–16434 Filed 7–10–09; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. OR09–18–000]

Tesoro Refining and Marketing Company, Complainant v. SFPP L.P., Respondent; Notice of Complaint

July 2, 2009.

Take notice that on July 1, 2009, Tesoro Refining and Marketing Company (Tesoro) filed a formal complaint against SFPP L.P. (SFPP) pursuant to Rule 206 of the Rules of Practice and Procedure of the Federal Energy Regulatory Commission, 18 CFR 385.206; the Procedural Rules Applicable to Oil Pipeline Proceedings, 18 CFR 343.2; sections 1(5), 8, 9, 13, 15 and 16 of the Interstate Commerce Act (ICA), 49 U.S.C. App. §§ 1(5), 8, 9, 13, 15 and 16 (1984) and section 1803 of the Energy Policy Act of 1992 (EPAct).

Tesoro alleges that SFPP was over-recovering its cost of service in 2007

and 2008 and, therefore, was not entitled to increase its rates using the indexation methodology in 2008 and is not entitled to do so in 2009. Among other things, Tesoro requests that the Commission determine that the rates established by SFPP are unjust and unreasonable.

Tesoro certifies that copies of the complaint were served on the contacts for SFPP as listed on the Commission's list of Corporate Officials.

Any person desiring to intervene or to protest this filing must file in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211, 385.214). Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a notice of intervention or motion to intervene, as appropriate. The Respondent's answer and all interventions, or protests must be filed on or before the comment date. The Respondent's answer, motions to intervene, and protests must be served on the Complainants.

The Commission encourages electronic submission of protests and interventions in lieu of paper using the ''eFiling'' link at *http://www.ferc.gov.* Persons unable to file electronically should submit an original and 14 copies of the protest or intervention to the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426.

This filing is accessible on-line at *http://www.ferc.gov,* using the ''eLibrary'' link and is available for review in the Commission's Public Reference Room in Washington, DC. There is an ''eSubscription'' link on the Web site that enables subscribers to receive e-mail notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please e-mail *FERCOnlineSupport@ferc.gov,* or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Comment Date: 5 p.m. Eastern Time on July 21, 2009

Kimberly D. Bose,

Secretary.

[FR Doc. E9–16436 Filed 7–10–09; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. OR09–19–000]

Tesoro Refining and Marketing Company, Complainant v. Calnev Pipe Line, L.L.C., Respondent; Notice of Complaint

July 2, 2009.

Take notice that on July 1, 2009, Tesoro Refining and Marketing Company (Tesoro) filed a formal complaint against Calnev Pipe Line, L.L.C. (Calnev) pursuant to Rule 206 of the Rules of Practice and Procedure of the Federal Energy Regulator Commission, 18 CFR 385.206; the Procedural Rules Applicable to Oil Pipeline Proceedings, 18 CFR 343.2, sections 1(5), 8, 9, 13, 15, and 16 of the Interstate Commerce Act (ICA), 49 U.S.C. App. §§ 1(5), 8, 9, 13, 15 and 16 (1984); and section 1803 of the Energy Policy Act of 1992 (EPAct).

Tesoro alleges that Calnev is over-recovering its cost of service in 2008 and, therefore, is not entitled to increase its rates using the indexation methodology in 2009. Among other things, Tesoro requests that the Commission determine that the rates established by Calnev are unjust and unreasonable.

Tesoro certifies that copies of the complaint were served on the contacts for Calnev as listed on the Commission's list of Corporate Officals.

Any person desiring to intervene or to protest this filing must file in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211, 385.214). Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a notice of intervention or motion to intervene, as appropriate. The Respondent's answer and all interventions, or protests must be filed on or before the comment date. The Respondent's answer, motions to intervene, and protests must be served on the Complainants.

The Commission encourages electronic submission of protests and interventions in lieu of paper using the ''eFiling'' link at *http://www.ferc.gov*. Persons unable to file electronically should submit an original and 14 copies of the protest or intervention to the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426.

This filing is accessible online at *http://www.ferc.gov*, using the ''eLibrary'' link and is available for review in the Commission's Public Reference Room in Washington, DC. There is an ''eSubscription'' link on the Web site that enables subscribers to receive e-mail notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please e-mail *FERCOnlineSupport@ferc.gov*, or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Comment Date: 5 p.m. Eastern Time on July 21, 2009.

Kimberly D. Bose,

Secretary.

[FR Doc. E9–16437 Filed 7–10–09; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. OR09–17–000]

Tesoro Refining and Marketing Company, Complainant v. SFPP L.P., Respondent; Notice of Complaint

July 2, 2009.

Take notice that on June 30, 2009, Tesoro Refining and Marketing Company (Tesoro) filed a formal complaint against SFPP L.P. (SFPP) pursuant to Rule 206 of the Rules of Practice and Procedure of the Federal Energy Regulatory Commission, 18 CFR 385.206; the Procedural Rules Applicable to Oil Pipeline Proceedings, 18 CFR 343.2; sections 1(5), 8, 9, 13, 15 and 16 of the Interstate Commerce Act, 49 U.S.C. App. §§ 1(5), 8, 9, 13, 15 and 16 (1984) and section 1803 of the Energy Policy Act of 1992. Among other things, Tesoro alleges that SFPP was over-recovering its cost of service in 2007 and 2008 and, therefore, charged Tesoro excessive rates that are unjust and unreasonable.

Tesoro certifies that copies of the complaint were served on the contacts for SFPP as listed on the Commission's list of Corporate Officials.

Any person desiring to intervene or to protest this filing must file in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211, 385.214). Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a notice of intervention or motion to intervene, as

appropriate. The Respondent's answer and all interventions, or protests must be filed on or before the comment date. The Respondent's answer, motions to intervene, and protests must be served on the Complainants.

The Commission encourages electronic submission of protests and interventions in lieu of paper using the ''eFiling'' link at *http://www.ferc.gov*. Persons unable to file electronically should submit an original and 14 copies of the protest or intervention to the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426.

This filing is accessible online at *http://www.ferc.gov*, using the ''eLibrary'' link and is available for review in the Commission's Public Reference Room in Washington, DC. There is an ''eSubscription'' link on the Web site that enables subscribers to receive e-mail notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please e-mail *FERCOnlineSupport@ferc.gov*, or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Comment Date: 5 p.m. Eastern Time on July 20, 2009.

Kimberly D. Bose,

Secretary.

[FR Doc. E9–16435 Filed 7–10–09; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. OR09–15–000]

Tesoro Refining and Marketing Company, Complainant v. Calnev Pipe Line, L.L.C., Respondent; Notice of Complaint

July 2, 2009.

Take notice that on June 30, 2009, Tesoro Refining and Marketing Company (Tesoro) filed a formal complaint against Calnev Pipe Line, L.L.C. (Calnev) pursuant to Rule 206 of the Rules of Practice and Procedure of the Federal Energy Regulatory Commission, 18 CFR 385.206; the Procedural Rules Applicable to Oil Pipeline Proceedings, 18 CFR 343.2, sections 1(5), 8, 9, 13, 15, and 16 of the Interstate Commerce Act (ICA), 49 U.S.C. App. §§ 1(5), 8, 9, 13, 15 and 16 (1984); and section 1803 of the Energy Policy Act of 1992 (EPAct). Among other things, Tesoro alleges that Calnev was over-recovering its cost of service in 2007 and 2008 and, therefore, charged Tesoro excessive rates that are unjust and unreasonable.

Any person desiring to intervene or to protest this filing must file in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211, 385.214). Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a notice of intervention or motion to intervene, as appropriate. The Respondent's answer and all interventions or protests must be filed on or before the comment date. The Respondent's answer, motions to intervene, and protests must be served on the Complainants.

The Commission encourages electronic submission of protests and interventions in lieu of paper using the ''eFiling'' link at *http://www.ferc.gov.* Persons unable to file electronically should submit an original and 14 copies of the protest or intervention to the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426.

This filing is accessible on-line at *http://www.ferc.gov,* using the ''eLibrary'' link and is available for review in the Commission's Public Reference Room in Washington, DC. There is an ''eSubscription'' link on the Web site that enables subscribers to receive e-mail notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please e-mail *FERCOnlineSupport@ferc.gov,* or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Comment Date: 5 p.m. Eastern Time on July 20, 2009.

Kimberly D. Bose,

Secretary.

[FR Doc. E9–16433 Filed 7–10–09; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. EL09–62–000]

Calpine Corporation, Citigroup Energy Inc., Dynegy Power Marketing, Inc., J.P. Morgan Ventures Energy Corporation, BE CA LLC, Mirant Energy Trading, LLC, NRG Energy, Inc., Powerex Corporation, and RRI Energy, Inc., Complainants v. California Independent System Operator Corporation, Respondent.; Notice of Complaint

July 2, 2009.

Take notice that on June 30, 2009, Calpine Corporation, Citigroup Energy Inc., Dynegy Power Marketing, Inc., J.P. Morgan Ventures Energy Corporation, BE CA, LLC, Mirant Energy Trading, LLC, NRG Energy, Inc., Powerex Corporation, and RRI Energy, Inc., (Complainants) filed a formal complaint against the California Independent System Operator Corporation (Respondent) pursuant to section 206 of the Federal Power Act, alleging that section 11.29.17.1 of Respondent's Market Redesign and Technology Upgrade Tariff is unjust and unreasonable and unduly discriminatory.

The Complainants certify that copies of the complaint were served on the contacts for Respondent as listed on the Commission's list of Corporate Officials.

Any person desiring to intervene or to protest this filing must file in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211, 385.214). Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a notice of intervention or motion to intervene, as appropriate. The Respondent's answer and all interventions, or protests must be filed on or before the comment date. The Respondent's answer, motions to intervene, and protests must be served on the Complainants.

The Commission encourages electronic submission of protests and interventions in lieu of paper using the ''eFiling'' link at *http://www.ferc.gov.* Persons unable to file electronically should submit an original and 14 copies of the protest or intervention to the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426.

This filing is accessible on-line at *http://www.ferc.gov,* using the

''eLibrary'' link and is available for review in the Commission's Public Reference Room in Washington, DC. There is an ''eSubscription'' link on the Web site that enables subscribers to receive e-mail notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please e-mail *FERCOnlineSupport@ferc.gov,* or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Comment Date: 5 p.m. Eastern Time on July 20, 2009.

Kimberly D. Bose,

Secretary.

[FR Doc. E9–16431 Filed 7–10–09; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. OR09–14–000]

Tesoro Refining and Marketing Company, Complainant v. Calnev Pipe Line, LLC, Respondent; Notice of Complaint

July 2, 2009.

Take notice that on June 30, 2009, Tesoro Refining and Marketing Company (Tesoro) filed a formal complaint against Calnev Pipe Line, LLC (Calnev) pursuant to Rule 206 of the Rules of Practice and Procedure of the Federal Energy Regulatory Commission, 18 CFR 385.206; the Procedural Rules Applicable to Oil Pipeline Proceedings, 18 CFR 343.2, sections 1(5), 8, 9, 13, 15, and 16 of the Interstate Commerce Act (ICA), 49 U.S.C. App. §§ 1(5), 8, 9, 13, 15 and 16 (1984); and section 1803 of the Energy Policy Act of 1992 (EPAct).

Tesoro alleges that Calnev has overstated its cost of service in the 2007 and 2008 Form 6 filed with the Commission. Tesoro requests that the Commission determine that the cost of service methodology employed by Calnev in the 2007 and 2008 Form 6s improperly characterized Calnev's cost of service, resulting in unjust and unreasonable rates, thereby violating sections 1(4) and 1(5) of the ICA and section 343.2(c)(1) of the Commission's regulations.

Tesoro certifies that copies of the complaint were served on the contacts for Calnev as listed on the Commission's list of Corporate Officials.

Any person desiring to intervene or to protest this filing must file in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211, 385.214). Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a notice of intervention or motion to intervene, as appropriate. The Respondent's answer and all interventions, or protests must be filed on or before the comment date. The Respondent's answer, motions to intervene, and protests must be served on the Complainants.

The Commission encourages electronic submission of protests and interventions in lieu of paper using the ''eFiling'' link at *http://www.ferc.gov.* Persons unable to file electronically should submit an original and 14 copies of the protest or intervention to the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426.

This filing is accessible on-line at *http://www.ferc.gov,* using the ''eLibrary'' link, and is available for review in the Commission's Public Reference Room in Washington, DC. There is an ''eSubscription'' link on the Web site that enables subscribers to receive e-mail notification when a document is added to a subscribed docket(s). For assistance with any FERC Online service, please e-mail *FERCOnlineSupport@ferc.gov,* or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Comment Date: 5 p.m. Eastern Time on July 20, 2009.

Kimberly D. Bose,

Secretary.

[FR Doc. E9–16432 Filed 7–10–09; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. ER09–1351–000]

EPLP Energy Services, LLC; Supplemental Notice That Initial Market-Based Rate Filing Includes Request for Blanket Section 204 Authorization

July 6, 2009.

This is a supplemental notice in the above-referenced proceeding of EPLP Energy Services, LLC's application for market-based rate authority, with an accompanying rate tariff, noting that such application includes a request for blanket authorization, under 18 CFR Part 34, of future issuances of securities and assumptions of liability.

Any person desiring to intervene or to protest should file with the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC, 20426, in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 385.214). Anyone filing a motion to intervene or protest must serve a copy of that document on the Applicant.

Notice is hereby given that the deadline for filing protests with regard to the applicant's request for blanket authorization, under 18 CFR Part 34, of future issuances of securities and assumptions of liability, is July 27, 2009.

The Commission encourages electronic submission of protests and interventions in lieu of paper, using the FERC Online links at *http://www.ferc.gov.* To facilitate electronic service, persons with Internet access who will eFile a document and/or be listed as a contact for an intervenor must create and validate an eRegistration account using the eRegistration link. Select the eFiling link to log on and submit the intervention or protests.

Persons unable to file electronically should submit an original and 14 copies of the intervention or protest to the Federal Energy Regulatory Commission, 888 First St. NE., Washington, DC, 20426.

The filings in the above-referenced proceeding are accessible in the Commission's eLibrary system by clicking on the appropriate link in the above list.

They are also available for review in the Commission's Public Reference Room in Washington, DC. There is an eSubscription link on the Web site that enables subscribers to receive e-mail notification when a document is added to a subscribed dockets(s). For assistance with any FERC Online service, please e-mail *FERCOnlineSupport@ferc.gov.* or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Kimberly D. Bose,

Secretary.

[FR Doc. E9–16447 Filed 7–10–09; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. ER09–1357–000]

Altair Energy Trading, Inc.; Supplemental Notice That Initial Market-Based Rate Filing Includes Request for Blanket Section 204 Authorization

July 6, 2009.

This is a supplemental notice in the above-referenced proceeding of Altair Energy Trading, Inc.'s application for market-based rate authority, with an accompanying rate tariff, noting that such application includes a request for blanket authorization, under 18 CFR Part 34, of future issuances of securities and assumptions of liability.

Any person desiring to intervene or to protest should file with the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC, 20426, in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 385.214). Anyone filing a motion to intervene or protest must serve a copy of that document on the Applicant.

Notice is hereby given that the deadline for filing protests with regard to the applicant's request for blanket authorization, under 18 CFR part 34, of future issuances of securities and assumptions of liability, is July 27, 2009.

The Commission encourages electronic submission of protests and interventions in lieu of paper, using the FERC Online links at *http://www.ferc.gov.* To facilitate electronic service, persons with Internet access who will eFile a document and/or be listed as a contact for an intervenor must create and validate an eRegistration account using the eRegistration link. Select the eFiling link to log on and submit the intervention or protests.

Persons unable to file electronically should submit an original and 14 copies of the intervention or protest to the Federal Energy Regulatory Commission, 888 First St. NE., Washington, DC, 20426.

The filings in the above-referenced proceeding are accessible in the Commission's eLibrary system by clicking on the appropriate link in the above list.

They are also available for review in the Commission's Public Reference Room in Washington, DC. There is an eSubscription link on the Web site that enables subscribers to receive e-mail notification when a document is added to a subscribed dockets(s). For assistance with any FERC Online service, please e-mail *FERCOnlineSupport@ferc.gov.* or call (866) 208–3676 (toll free). For TTY, call (202) 502–8659.

Kimberly D. Bose,

Secretary.

[FR Doc. E9–16445 Filed 7–10–09; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. CP09–437–000]

Columbia Gas Transmission, LLC; Notice of Request Under Blanket Authorization

July 2, 2009.

Take notice that on June 19, 2009, Columbia Gas Transmission, LLC (Columbia), 5151 San Felipe, Suite 2500, Houston, Texas 77056, filed in Docket No. CP09–437–000, an application pursuant to sections 157.205, 157.208(b) and 157.216(b) of the Commission's Regulations under the Natural Gas Act (NGA) as amended, to construct, replace, relocate, and abandon certain natural gas facilities at the Cobb compressor station system near Clendenin, Kanawha County, West Virginia, under Columbia's blanket certificate issued in Docket No. CP83–76–000,[1] all as more fully set forth in the application which is on file with the Commission and open to the public for inspection.

Columbia proposes to construct and operate one 4,500 horsepower compressor unit at Columbia's Cobb compressor station. Columbia states that it would construct and operate approximately 0.7 miles of 16-inch diameter pipeline and appurtenances which would replace approximately 0.68 miles of 10-inch and 16-inch diameter pipeline in three segments on Columbia's Lines N and S, both in Kanawha County. Columbia also states that it would make minor modifications to its existing receipt point from Caraline Energy and construct an additional new receipt point for Caraline Energy. Columbia further states that the proposed new facilities and modifications would cost an estimated $16,100,000 to construct.

Any questions concerning this application may be directed to Fredric J. George, Senior Counsel, Columbia Gas Transmission, LLC, P.O. Box 1273, Charleston, West Virginia 25325–1273 or via telephone at (304) 357–2359 or by facsimile (304) 357–3206.

This filing is available for review at the Commission or may be viewed on the Commission's Web site at *http://www.ferc.gov,* using the ''eLibrary'' link. Enter the docket number excluding the last three digits in the docket number filed to access the document. For assistance, please contact FERC Online Support at FERC *OnlineSupport@ferc.gov* or call toll-free at (866) 206–3676, or, for TTY, contact (202) 502–8659. Comments, protests and interventions may be filed electronically via the Internet in lieu of paper. See 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's Web site under the ''e-Filing'' link. The Commission strongly encourages intervenors to file electronically.

Any person or the Commission's staff may, within 60 days after issuance of the instant notice by the Commission, file pursuant to Rule 214 of the Commission's Procedural Rules (18 CFR 385.214) a motion to intervene or notice of intervention and pursuant to section 157.205 of the regulations under the NGA (18 CFR 157.205), a protest to the request. If no protest is filed within the time allowed therefore, the proposed activity shall be deemed to be authorized effective the day after the time allowed for filing a protest. If a protest is filed and not withdrawn within 30 days after the allowed time for filing a protest, the instant request shall be treated as an application for authorization pursuant to section 7 of the NGA.

Kimberly D. Bose,

Secretary.

[FR Doc. E9–16443 Filed 7–10–09; 8:45 am]

BILLING CODE 6717–01–P

[1] 22 FERC ¶ 62,029 (1983).

ENVIRONMENTAL PROTECTION AGENCY

[FRL–8929–5; EPA–HQ–OEI–2008–0062]

Type of Action: New; Establishment of a New System of Records for the Science Advisory Board (SAB) Database of Scientific and Technical Experts

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: Pursuant to the provisions of the Privacy Act of 1974 (5 U.S.C. 552a), the Office of the Administrator, SAB Staff Office is giving notice that it proposes to create a new system of

records for the SAB Database of Scientific and Technical Experts.

DATES: Persons wishing to comment on this system of records notice must do so by August 24, 2009.

ADDRESSES: Submit your comments, identified by Docket ID No. EPA–HQ–2008–0062, by one of the following methods:

- *http://www.regulations.gov*: Follow the online instructions for submitting comments.
- *E-mail: oei.docket@epa.gov*.
- *Fax:* 202–566–1752.
- *Mail:* OEI Docket, Environmental Protection Agency, Mailcode: 2822T, 1200 Pennsylvania Ave., NW., Washington, DC 20460.
- *Hand Delivery:* OEI Docket, EPA/DC, EPA West Building, Room 3334, 1301 Constitution Ave., NW., Washington, DC. Such deliveries are only accepted during the Docket's normal hours of operation, and special arrangements should be made for deliveries of boxed information.

Instructions: Direct your comments to Docket ID No. EPA–HQ–OEI–2008–0062. EPA's policy is that all comments received will be included in the public docket without change and may be made available online at *http://www.regulations.gov*, including any personal information provided, unless the comment includes information claimed to be Confidential Business Information (CBI) or other information for which disclosure is restricted by statute. Do not submit information that you consider to be CBI or otherwise protected through *http://www.regulations.gov*. The *http://www.regulations.gov* Web site is an ''anonymous access'' system, which means EPA will not know your identity or contact information unless you provide it in the body of your comment. If you send an e-mail comment directly to EPA without going through *http://www.regulations.gov* your e-mail address will be automatically captured and included as part of the comment that is placed in the public docket and made available on the Internet. If you submit an electronic comment, EPA recommends that you include your name and other contact information in the body of your comment and with any disk or CD–ROM you submit. If EPA cannot read your comment due to technical difficulties and cannot contact you for clarification, EPA may not be able to consider your comment. Electronic files should avoid the use of special characters, any form of encryption, and be free of any defects or viruses. For additional information about EPA's public docket visit the EPA Docket Center homepage at *http://www.epa.gov/epahome/dockets.htm*.

Docket: All documents in the docket are listed in the *http://www.regulations.gov* index. Although listed in the index, some information is not publicly available, *e.g.*, CBI or other information for which disclosure is restricted by statute. Certain other material, such as copyrighted material, will be publicly available only in hard copy. Publicly available docket materials are available either electronically in *http://www.regulations.gov* or in hard copy at the OEI Docket, EPA/DC, EPA West Building, Room 3334, 1301 Constitution Ave., NW., Washington, DC. The Public Reading Room is open from 8:30 a.m. to 4:30 p.m., Monday through Friday excluding legal holidays. The telephone number for the Public Reading Room is (202) 566–1744, and the telephone number for the OEI Docket is (202) 566–1745.

FOR FURTHER INFORMATION CONTACT: Dr. Angela Nugent, Special Assistant to the Director, SAB Staff Office, U.S. Environmental Protection Agency, Mail Code 1400F, 1200 Pennsylvania Avenue, NW., Washington, DC 20460; telephone number (202) 343–9981; e-mail address: *nugent.angela@epa.gov*.

SUPPLEMENTARY INFORMATION:

I. General Information

The U.S. Environmental Protection Agency plans to create a Privacy Act system of records to centralize, standardize and safeguard the information submitted by experts who support three scientific and technical advisory committees (*i.e.*, the Science Advisory Board, the Clean Air Scientific Advisory Committee, and the Advisory Council on Clean Air Compliance Analysis) that report to EPA's Administrator. The SAB Staff Office: (1) Requests nominations from the public for qualified individuals to serve as experts on committees and panels that advise the Administrator; (2) identifies experts to become Special Government Employees (SGEs) to serve on the advisory committees and panels; (3) manages the SGEs' personnel paperwork and ensures that SGEs comply with ethics training and financial disclosure requirements of the Ethics in Government Act, 5 U.S.C. App. 4; and (4) coordinates experts' participation in approximately fifty advisory projects per year and approximately eighty meetings per year. The SAB Staff Office conducts these activities to provide the Administrator with scientific advice from balanced committees of qualified experts on high priority science issues.

To manage the above activities in an efficient manner that protects the privacy of the scientific experts, the SAB Staff Office has integrated personal information provided by the experts in a central SAB Database. Consolidating information about individual experts in a central location allows for consistent procedures to be followed for protecting privacy-related information necessary to manage and support the advisory committees for which the SAB Staff Office is responsible.

Records in the SAB Database of Scientific and Technical Experts are safeguarded from unauthorized use. Only SAB Staff Office personnel and a very limited number of database support contractors have access to consolidated personal information in the password-protected SAB databases. Some generally available information such as experts' institutional affiliation and biographical sketches are accessible via the EPA SAB Web site (*http://www.epa.gov/sab*). Security procedures have been approved through the Application Development Process administered by EPA's Office of Environmental Information.

The system is maintained at the U.S. EPA, 1025 F Street, NW., Suite 3600, Mail Code 1400F, Washington, DC 20004.

Dated: June 22, 2009.

Linda A. Travers,

Acting Assistant Administrator and Chief Information Officer.

EPA–58

SYSTEM NAME:

EPA Science Advisory Board (SAB) Database of Scientific and Technical Experts.

SYSTEM LOCATION:

U.S. EPA, 1025 F Street, NW., Suite 3600, Mail Code 1400F, Washington, DC 20004.

CATEGORIES OF INDIVIDUALS COVERED BY THE SYSTEM:

Scientific and technical experts currently serving on committees and panels administered by the SAB Staff Office; scientific and technical experts who have served on such committees and panels since 2002; and scientific and technical experts nominated to serve on planned SAB Staff Office-supported committees and panels.

CATEGORIES OF RECORDS IN THE SYSTEM:

Name, home contact information (address and telephone number); professional contact information (*e.g.*, professional title, institutional affiliation, and work contact information); terms of appointment to

advisory committees and panels; expertise information (*e.g.*, *curricula vitae* and professional biographical sketches); and administrative history information (*e.g.*, history of personnel actions, confidential financial disclosure forms, and annual ethics training).

AUTHORITY FOR MAINTENANCE OF THE SYSTEM (INCLUDES ANY REVISIONS OR AMENDMENTS):

The authority for the establishment or appointment of these advisory committees is as follows: For the SAB, the Environmental Research, Development, and Demonstration Authorization Act, 42 U.S.C. 4365; for the Clean Air Scientific Advisory Committee, section 109(d)(2) of the Clean Air Act, 42 U.S.C. 7409(d)(2); and for the Advisory Council on Clean Air Compliance Analysis, section 312(f) of the Clean Air Act, 42 U.S.C. 7612(f).

PURPOSE(S):

This system of records is being created to assist EPA with providing management and technical support to three scientific and technical advisory committees (the SAB, the Clean Air Scientific Advisory Committee, and the Advisory Council on Clean Air Compliance Analysis) that report to the EPA Administrator. The SAB Staff Office requests nominations of experts from the public wishing to nominate themselves or others for committees and panels providing advice; identifies experts to become Special Government Employees (SGEs) serving on advisory committees and panels; manages their personnel paperwork; ensures that SGEs comply with ethics training and financial disclosure requirements of the Ethics in Government Act; and coordinates experts' participation in approximately fifty advisory projects per year and approximately eighty meetings per year. The SAB Staff Office conducts these activities to provide the EPA Administrator with scientific advice from balanced committees of qualified experts on high priority science issues. The SAB Database of Scientific and Technical Experts assists the SAB Staff Office to achieve this goal in an efficient manner that protects the privacy of scientific experts.

ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM, INCLUDING CATEGORIES OF USERS, AND THE PURPOSES OF SUCH USES:

General routine uses A, B, C, E, F, G, H, I, J, K and L apply to this system.

POLICIES AND PRACTICES FOR STORING, RETRIEVING, ACCESSING, RETAINING, AND DISPOSING OF RECORDS IN THE SYSTEM:

STORAGE:

Records will be maintained in electronic form and stored in the password-protected SAB database on EPA's client server in Research Triangle Park.

RETRIEVABILITY:

Personally-identifiable information is retrieved by expert's name or by committee or panel name.

SAFEGUARDS:

Only SAB Staff Office personnel and a very limited set of database support contractors have access to consolidated personal information in the password-protected SAB database. Security procedures have been approved through the Application Development Process administered by EPA's Office of Environmental Information. Personnel have taken security awareness training.

RETENTION AND DISPOSAL:

File is cumulative and is maintained indefinitely.

SYSTEM MANAGER(S) AND ADDRESS:

Dr. Anthony Maciorowski, Deputy Director, SAB Staff Office, U.S. Environmental Protection Agency, Mail Code 1400F, 1200 Pennsylvania Avenue, NW., Washington, DC 20460.

NOTIFICATION PROCEDURES:

Any individual who wants to know whether this system of records contains a record about him or her, who wants access to his or her record, or who wants to contest the contents of a record, should make a written request to the Freedom of Information Office, Attention: Privacy Act Officer. Complete EPA Privacy Act procedures are set out at 40 CFR part 16.

RECORD ACCESS PROCEDURES:

Requesters will be required to provide adequate identification, such as a driver's license, employee identification card, or other identifying document.

CONTESTING RECORDS PROCEDURES:

Requests for correction or amendment must identify the record to be changed and the corrective action sought. Complete EPA Privacy Act procedures are set out at 40 CFR part 16.

RECORD SOURCE CATEGORIES:

Individuals who are scientific and/or technical experts.

SYSTEM EXEMPTED FROM CERTAIN PROVISIONS OF THE PRIVACY ACT:

None.

[FR Doc. E9–16493 Filed 7–10–09; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[EPA-New England Region I—EPA–R01–OW–2009–0304; FRL–8930–1]

Maine Marine Sanitation Device Standard—Receipt of Petition

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice—receipt of petition.

SUMMARY: Notice is hereby given that a petition has been received from the State of Maine requesting a determination by the Regional Administrator, U.S. Environmental Protection Agency, that adequate facilities for the safe and sanitary removal and treatment of sewage from all vessels are reasonably available for the waters of Camden, Rockport, Rockland, and portions of Owls Head.

DATES: Comments must be submitted by August 12, 2009.

ADDRESSES: Submit your comments, identified by Docket ID No. EPA–R01–OW–2009–0304, by one of the following methods: *http://www.regulations.gov*, Follow the on-line instructions for submitting comments.

- *E-mail: rodney.ann@epa.gov*.
- *Fax:* (617) 918–0538.

Mail and hand delivery: U.S. Environmental Protection Agency—New England Region, One Congress Street, Suite 1100, COP, Boston, MA 02114–2023. Deliveries are only accepted during the Regional Office's normal hours of operation (8 a.m.–5 p.m., Monday through Friday, excluding legal holidays), and special arrangements should be made for deliveries of boxed information.

Instructions: Direct your comments to Docket ID No. EPA–R01–OW–2009–0304. EPA's policy is that all comments received will be included in the public docket without change and may be made available online at *http://www.regulations.gov*, including any personal information provided, unless the comment includes information claimed to be Confidential Business Information (CBI) or other information whose disclosure is restricted by statute. Do not submit information that you consider to be CBI or otherwise protected through http://www.regulations.gov, or e-mail. The *http://www.regulations.gov* Web site is

an ''anonymous access'' system, which means EPA will not know your identity or contact information unless you provide it in the body of your comment. If you send an e-mail comment directly to EPA without going through *http://www.regulations.gov* your e-mail address will be automatically captured and included as part of the comment that is placed in the public docket and made available on the Internet. If you submit an electronic comment, EPA recommends that you include your name and other contact information in the body of your comment and with any disk or CD–ROM you submit. If EPA cannot read your comment due to technical difficulties and cannot contact you for clarification, EPA may not be able to consider your comment. Electronic files should avoid the use of special characters, any form of encryption, and be free of any defects or viruses.

Docket: All documents in the docket are listed in the *http://www.regulations.gov* index. Although listed in the index, some information is not publicly available, e.g., CBI or other information whose disclosure is restricted by statute. Certain other material, such as copy-righted material, will be publicly available only in hard copy. Publicly available docket materials are available either electronically in *http://www.regulations.gov* or in hard copy at the U.S. Environmental Protection Agency—New England Region, One Congress Street, Suite 1100, COP, Boston, MA 02114–2023. Such deliveries are only accepted during the Regional Office's normal hours of operation, and special arrangements should be made for deliveries of boxed information. The Regional Office is open from 8 a.m.–5 p.m., Monday through Friday, excluding legal holidays. The telephone number is (617) 918–1538.

FOR FURTHER INFORMATION CONTACT: Ann Rodney, U.S. Environmental Protection Agency—New England Region, One Congress Street, Suite 1100, COP, Boston, MA 02114–2023. Telephone: (617) 918–1538, Fax number: (617) 918–0538; e-mail address: *rodney.ann@epa.gov*.

SUPPLEMENTARY INFORMATION: Notice is hereby given that a petition has been received from the State of Maine requesting a determination by the Regional Administrator, U.S. Environmental Protection Agency, pursuant to section 312(f)(3) of Public Law 92–500 as amended by Public Law 95–217 and Public Law 100–4, that adequate facilities for the safe and sanitary removal and treatment of sewage from all vessels are reasonably available for the Camden, Rockport, Rockland and Owls Head area.

The proposed No Discharge Area for Camden, Rockport, Rockland and Portions of Owls Head:

Waterbody/general area	From longitude	From latitude	To longitude	To latitude
From USCG navigational aid red and white bell ''CH'' west across the water to Northeast Point in Camden.	69°2′16.1″ W	44°12′40.98″ N	69°2′47.61″ W	44°12′32.84″ N
From Northeast point west following the shore to the head of navigation in Camden Harbor at the mouth of the ''Megunticook River'' in Camden.	69°2′47.61″ W	44°12′32.84″ N	69°3′51.14″ W	44°12′37.58″ N
South following the shore to the head of navigation in Rockport Harbor and the mouth of the ''Goose River'' in Rockport.	69°3′51.14″ W	44°12′37.58″ N	69°4′23.79″ W	44°11′11.35″ N
South following the shore to the extent of navigation of Rockland Harbor and the mouth of the Unnamed stream in Rockland.	69°4′23.79″ W	44°11′11.35″ N	69°6′11.65″ W	44°4′41.42″ N
East following the shore to ''Owls Head'' in the town of Owls Head	69°6′11.65″ W	44°4′41.42″ N	69°2′36.46″ W	44°5′30.58″ N
East in a straight line across the water to USGC navigational green can ''7''.	69°2′36.46″ W	44°5′30.58″ N	69°2′30.06″ W	44°5′24.95″ N
North in a straight line across the water to USCG navigational aid red and white bell ''CH''.	69°2′30.06″ W	44°5′24.95″ N	69°2′16.1″ W	44°12′40.98″ N

The boundaries were chosen based on easy line-of-sight locations and generally represent all navigational waters. The area includes the municipal waters of Camden, Rockport, Rockland and portions of Owls Head.

There are marinas, yacht clubs and public landings/piers in the proposed area with a combination of mooring fields and dock space for the recreational and commercial vessels. Maine has certified that there are six pumpout facilities within the proposed area available to the boating public and the facilities are connected to the municipal sewage system. A list of the facilities, locations, contact information, hours of operation, and water depth is provided at the end of this petition.

Maine has provided documentation indicating that the total vessel population is estimated to be 1151 in the proposed area. It is estimated that 813 of the total vessel population may have a Marine Sanitation Device (MSD) of some type.

The proposed area is identified as a High Value Wildlife Habitat by the U. S. Fish and Wildlife Service. The area constitutes almost 17 square miles of marine habitat, 450 acres of wetlands, and essential habitat for bald eagles. The area is adjacent to and bordered by several State parks including the Clam Cove Scenic Area, and the Owls Head Regional Recreation Area. There is one large marina, a yacht club and public boating facilities in Camden, and a boatyard and a large City owned park and dock in Rockland, and three large marinas, two boat repair facilities, working fishing wharfs and a city waterfront operation, together serving roughly 1151 boats. This area is a popular destination for boaters due to its natural environmental diversity and would benefit from a No Discharge Area.

Name	Location	Contact information	Hours	Mean low water depth (in feet)
Harbormaster	Town Landing, Camden	207–236–3353, VHF 16	8 a.m.–5 p.m., 7 days	N/A
Wayfarer Marine	59 Sea Street, Camden	207–236–4378, VHF 9	8 a.m.–5 p.m., 7 days	10
Journey's End Marina	120 Tilson Ave., Rockland	207–598–4444, VHF 9	8 a.m.–5 p.m., 7 days	8
Landings Marina	Commercial Street, Rockland	207–596–6573, VHF 9	9 a.m.–5 p.m., 7 days	5

Name	Location	Contact information	Hours	Mean low water depth (in feet)
City of Rockland	Rockland Public Landing, Rockland.	207–594–0312, VHF 9	9 a.m.–5 p.m., 7 days	6
Trident Yacht Basin	60 Ocean Street, Rockland	207–236–8100, VHF 9	9 a.m.–5 p.m., 7 days	23

Dated: July 2, 2009.

Stephen S. Perkins,

Acting Regional Administrator, New England Region.

[FR Doc. E9–16488 Filed 7–10–09; 8:45 am]

BILLING CODE 6560–50–P

FEDERAL COMMUNICATIONS COMMISSION

Notice of Public Information Collection(s) Being Submitted to the Office of Management and Budget for Review and Approval, Comments Requested

July 6, 2009.

SUMMARY: The Federal Communications Commission, as part of its continuing effort to reduce paperwork burden invites the general public and other Federal agencies to take this opportunity to comment on the following information collection(s), as required by the Paperwork Reduction Act (PRA) of 1995, 44 U.S.C. 3501–3520. An agency may not conduct or sponsor a collection of information unless it displays a currently valid control number. No person shall be subject to any penalty for failing to comply with a collection of information subject to the Paperwork Reduction Act (PRA) that does not display a valid control number. Comments are requested concerning (a) whether the proposed collection of information is necessary for the proper performance of the functions of the Commission, including whether the information shall have practical utility; (b) the accuracy of the Commission's burden estimate; (c) ways to enhance the quality, utility, and clarity of the information collected; and (d) ways to minimize the burden of the collection of information on the respondents, including the use of automated collection techniques or other forms of information technology.

DATES: Written Paperwork Reduction Act (PRA) comments should be submitted on or before August 12, 2009. If you anticipate that you will be submitting PRA comments, but find it difficult to do so within the period of time allowed by this notice, you should advise the FCC contact listed below as soon as possible.

ADDRESSES: Direct all PRA comments to Nicholas A. Fraser, Office of Management and Budget, via fax at 202–395–5167 or via Internet at *Nicholas_A._Fraser@omb.eop.gov* and to *Judith-B.Herman@fcc.gov,* Federal Communications Commission, or an e-mail to *PRA@fcc.gov*.

FOR FURTHER INFORMATION CONTACT: For additional information, contact Judith B. Herman at 202–418–0214 or via the Internet at *Judith-B.Herman@fcc.gov.*

SUPPLEMENTARY INFORMATION:

OMB Control Number: 3060–0168.

Title: Section 43.43, Report of Proposed Changes in Depreciation Rates.

Form No.: N/A.

Type of Review: Extension of a currently approved collection.

Respondents: Business or other for-profit.

Number of Respondents: 24 respondents; 24 responses.

Estimated Time per Response: 250 hours.

Frequency of Response: On occasion reporting requirement and recordkeeping requirement.

Obligation to Respond: Required to obtain or retain benefits. Statutory authority for this information collection is contained in 47 U.S.C. 151, 152, 154, 161, 201–205, and 218–220.

Total Annual Burden: 6,000 hours.

Total Annual Cost: $784,320.

Privacy Act Impact Assessment: N/A.

Nature and Extent of Confidentiality: There is no need for confidentiality and respondents are not being asked to submit confidential information to the Commission. However, if the Commission requests respondents to submit information which they believe is confidential, respondents may request confidential treatment of such information under 47 CFR 0.459 of the Commission's rules.

Needs and Uses: The Commission will submit this information collection to the Office of Management and Budget (OMB) after this 60 day comment period in order to obtain the full three year clearance from them. The Commission is requesting an extension (no change in the reporting and/or recordkeeping requirements) of this information collection. The Commission is reporting a significant decrease in the estimated number of respondents/responses since this was last submitted to OMB in 2006. In 2006, the Commission reported 10 respondents/responses with 6,000 total annual burden hours. For this submission to the OMB, the number of respondents/responses increased to 24 with an estimated annual burden of 6,000 total annual burden hours and an increase in annual costs. The annual costs are now estimated to be $785,320 (no costs were estimated in 2006). The reasons for the change in burden are thus:

(1) The estimated time per response was changed from 6,000 hours to 250 hours;

(2) A re-estimate of the number of respondents/responses from 10 to 24 respondents; and

(3) The annual costs have been added to include a $32,680 filing fee per 47 CFR 1.1105.

43.43 establishes the reporting requirements for depreciation prescription purposes. Communication common carriers with annual operating revenues of $138 million or more that the Commission has found to be dominant must file information specified in Section 43.43 before making any change in the depreciation rates applicable to their operating plant. Section 220 also allows the Commission, in its discretion, to prescribe the form of any and all accounts, records, and memoranda to be kept by carriers subject to the Act, including the accounts, records and memoranda of the movement of traffic, as well as receipts and expenditures of moneys. Carriers are required to file four summary exhibits along with the underlying data used to generate them, and must provide the depreciation factors (*i.e.,* life, salvage, curve shape, depreciation reserve) required to verify the calculation of the carrier's depreciation expenses and rates. Mid-sized carriers are no longer required to file theoretical reserve studies. Certain price cap incumbent LECs in certain instances may request a waiver of the depreciation prescription process.

Marlene H. Dortch,

Secretary,

Federal Communications Commission.

[FR Doc. E9–16483 Filed 7–10–09; 8:45 am]

BILLING CODE 6712–01–P

FEDERAL COMMUNICATIONS COMMISSION

Notice of Public Information Collection(s) Being Reviewed by the Federal Communications Commission, Comments Requested

June 30, 2009.

SUMMARY: The Federal Communications Commission, as part of its continuing effort to reduce paperwork burden invites the general public and other Federal agencies to take this opportunity to comment on the following information collection(s), as required by the Paperwork Reduction Act (PRA) of 1995, 44 U.S.C. 3501–3520. An agency may not conduct or sponsor a collection of information unless it displays a currently valid control number. No person shall be subject to any penalty for failing to comply with a collection of information subject to the Paperwork Reduction Act (PRA) that does not display a valid control number. Comments are requested concerning: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the Commission, including whether the information shall have practical utility; (b) the accuracy of the Commission's burden estimate; (c) ways to enhance the quality, utility, and clarity of the information collected; and (d) ways to minimize the burden of the collection of information on the respondents, including the use of automated collection techniques or other forms of information technology.

DATES: Written Paperwork Reduction Act (PRA) comments should be submitted on or before September 11, 2009. If you anticipate that you will be submitting PRA comments, but find it difficult to do so within the period of time allowed by this notice, you should advise the FCC contact listed below as soon as possible.

ADDRESSES: Direct all PRA comments to Nicholas A. Fraser, Office of Management and Budget, via fax at 202–395–5167 or via Internet at *Nicholas_A._Fraser@omb.eop.gov* and to *Judith-B.Herman@fcc.gov,* Federal Communications Commission, or an e-mail to *PRA@fcc.gov*.

FOR FURTHER INFORMATION CONTACT: For additional information, contact Judith B. Herman at 202–418–0214 or via the Internet at *Judith-B.Herman@fcc.gov.*

SUPPLEMENTARY INFORMATION:

OMB Control Number: 3060–1031.

Title: Commission's Initiative to Implement Enhanced 911 (E911) Emergency Services.

Form No.: N/A.

Type of Review: Extension of a currently approved collection.

Respondents: Business or other for-profit; not-for-profit institutions; Federal Government; and State, local or tribal government.

Number of Respondents: 858 respondents; 1,992 responses.

Estimated Time per Response: 2–4 hours per requirement.

Frequency of Response: On occasion and one time reporting requirement, recordkeeping requirement and third party disclosure requirement.

Obligation to Respond: Voluntary. Statutory authority for this information collection is contained in 47 U.S.C. 154, 160, 201, 251–254, 303 and 332 unless otherwise noted.

Total Annual Burden: 10,168 hours.

Total Annual Cost: N/A.

Privacy Act Impact Assessment: N/A.

Needs and Uses: The Commission will submit this information collection to the Office of Management and Budget (OMB) after this 60-day comment period in order to obtain the full three-year clearance from them. The Commission is requesting an extension (no change in the reporting, recordkeeping and/or third party certification and notification requirements) of this information collection. There is a change in the estimated respondents/responses and the annual burden hours. The Commission is reporting 834 more responses. Therefore, the total annual burden hour estimate has increased by 3,592 hours. These adjusted increases reflect more accurate estimates.

Pursuant to the Commission's E911 rules, a wireless carrier must provide E911 service to a particular Public Safety Answering Point (PSAP) within six months if that PSAP makes a request for the service and is capable of receiving and utilizing the information provided. In the City of Richardson Order, the Commission adopted rules clarifying what constitutes a valid PSAP request so as to trigger a wireless carrier's obligation to provide service to a PSAP within six months.

In November 2002, the Commission released the City of Richardson Order on Reconsideration, modifying its E911 rules to provide additional clarification on the issue of PSAP readiness. The Commission's actions were intended to facilitate the E911 implementation process by encouraging parties to communicate with each other early in the implementation process, and to maintain a constructive, on-going dialog throughout the implementation process.

The Order contained three information collection requirements subject to the Paperwork Reduction Act for which the Commission seeks continued OMB approval:

(a) The Commission established a procedure whereby wireless carriers that have completed all necessary steps toward E911 implementation that are not dependent on PSAP readiness may have their compliance obligation temporarily tolled, if the PSAP is not ready to receive the information at the end of the six-month period, and the carrier files a certification to that effect with the Commission.

(b) As part of the certification and notification process (third party disclosure requirements), a carrier must notify the PSAP of its intent to file a certification with the Commission that the PSAP is not ready to receive and use the information. The PSAP is permitted to send a response to the carriers' notification to affirm that it is not ready to receive E911 information or to challenge the carrier's characterization of its state of readiness. Carriers are required to include any response they receive from the PSAP to their certification filing to the Commission.

(c) The Commission clarified that nothing in its rules prevented wireless carriers and PSAPs from mutually agreeing to an E911 deployment schedule at variance with the schedule contained in the Commission's rules. Carriers and PSAPs may choose to participate in the certification and private negotiation process. The Commission does not require participation.

The Commission will use the certification filings from wireless carriers to determine each carrier's compliance with its E911 obligations. The Commission will review carrier certifications to ensure that carriers have sufficiently explained the basis for their conclusion that a particular PSAP will not be ready and have identified all of the specific steps the PSAP has taken to provide the requested service. The Commission retains the discretion to investigate a carrier's certification and take enforcement action if appropriate.

The requirement that carriers notify affected PSAPs in writing, of their challenge, including a copy of the certification, will afford PSAPs an opportunity to review proposed certifications and present their respective views about their readiness to receive and use E911 information to the carrier and the Commission. The Commission will review the PSAP responses to determine whether there are any PSAP objections to particular certification filings. The clarification regarding mutually agreed upon alternative implementation schedules necessarily entails a third-party contact

information burden. However, the affected entities will receive the benefit of being able to adopt an E911 implementation schedule best suited to the specific circumstances.

Federal Communications Commission.

Marlene H. Dortch,

Secretary.

[FR Doc. E9–16484 Filed 7–10–09; 8:45 am]

BILLING CODE 6712–01–P

FEDERAL COMMUNICATIONS COMMISSION

[DA 09–1487]

Commencement of Digital Licensing for Low Power Television and TV Translators Beginning August 25, 2009 for Rural Areas and January 25, 2010 Nationwide

AGENCY: Federal Communications Commission.

ACTION: Notice.

SUMMARY: In this document, the Video Division of the Media Bureau announces that it will permit the filing of applications for new digital-only LPTV and TV translator stations, for major changes to existing analog and digital LPTV and TV translator facilities in those areas, and, in the case of incumbent analog stations, for digital companion channels on August 25, 2009 in rural areas and January 25, 2010 nationwide. No applications for new analog facilities will be accepted.

DATES: Applications will begin to be accepted August 25, 2009, subject to a geographic restriction, and without geographic restriction on January 25, 2010.

FOR FURTHER INFORMATION CONTACT: Shaun Maher (legal) or Hossein Hashemzadeh (technical) of the Video Division, Media Bureau, at (202) 418–1600.

SUPPLEMENTARY INFORMATION: Beginning August 25, 2009, all interested parties including incumbent LPTV and TV translator stations, may begin filing applications for new digital-only LPTV and TV translator stations, for major changes to existing analog and digital facilities and, in the case of incumbent analog stations, for digital companion channels, where such applications specify transmitting antenna site coordinates (geographic latitude and longitude) located more than 121 kilometers (75 miles) from the reference coordinates of the cities listed in 47 CFR 76.53 of the Commission's Rules. These applications will be filed on a first-come, first-served basis and will be ''cut-off'' daily.

Beginning January 25, 2010, all interested parties, including incumbent LPTV and TV translator stations, may begin filing applications for new digital-only LPTV and TV translator stations, for major changes to existing analog and digital LPTV and TV translator stations, and, in the case of incumbent analog stations, for digital companion channels without geographic restriction. Such applications will be filed on a first-come, first-served basis and will be ''cut-off'' daily.

All applications for new digital-only LPTV and TV translator stations or for major changes to existing digital or analog LPTV and TV translator stations are subject to a $705.00 filing fee. There is no application filing fee for the submission of flash-cut or digital companion channel applications or for applications for replacement digital translator stations as these applications are for minor changes. Applicants must file their applications electronically using FCC Form 346. Paper-filed applications will not be accepted. Instructions for use of the electronic filing system are available in the CDBS User's Guide, which can be accessed from the electronic filing Web site at: *http://www.fcc.gov/mb/cdbs.html.* For assistance with electronic filing, call the Media Bureau Help Desk at (202) 418–26MB (418–2662). Additional important reminders concerning the filing of applications were included in the Public Notice.

Paperwork Reduction Act Approval: The FCC Form 346 was assigned control number 3060–0016 and was approved by the Office of Management and Budget (OMB) on March 27, 2008.

Federal Communications Commission.

Barbara Kreisman,

Chief, Video Division, Media Bureau.

[FR Doc. E9–16485 Filed 7–10–09; 8:45 am]

BILLING CODE 6712–01–P

FEDERAL RETIREMENT THRIFT INVESTMENT BOARD

Sunshine Act; Notice of Meeting

TIME AND DATE: 9 a.m. (Eastern Time) July 20, 2009.

PLACE: 4th Floor Conference Room, 1250 H Street, NW., Washington, DC 20005.

STATUS: Parts will be open to the public and parts closed to the public.

MATTERS TO BE CONSIDERED:

Parts Open to the Public

1. Approval of the minutes of the June 16, 2009 Board member meeting.

2. Thrift Savings Plan activity report by the Executive Director.

a. Participant Activity Report.

b. Quarterly Investment Performance and Policy Review.

c. Legislative Report.

3. Discussion of Pending BGI/BlackRock Merger.

4. Quarterly Vendor Financial Reports.

5. IT Modernization Plan Update.

Parts Closed to the Public

6. Procurement.

7. Proprietary Information.

FOR FURTHER INFORMATION CONTACT: Thomas J. Trabucco, Director, Office of External Affairs, (202) 942–1640.

Dated: July 9, 2009.

Thomas K. Emswiler,

Secretary, Federal Retirement Thrift Investment Board.

[FR Doc. E9–16681 Filed 7–9–09; 4:15 pm]

BILLING CODE 6760–01–P

FEDERAL MARITIME COMMISSION

[Docket No. 09–03]

Naveena Exports, Ltd. v. Go-Trans, Inc.; Notice of Complaint and Assignment

Notice is given that a complaint has been filed with the Federal Maritime Commission (''Commission'') by Naveena Exports, Ltd., hereinafter ''Complainant.'' Complainant asserts that it is a foreign limited partnership organized under the laws of the State of Pakistan that manufactures and imports apparel goods to the United States. Complainant alleges that Respondent Go-Trans, Inc., is an Ocean Transportation Intermediary organized under the laws of the State of New York. Complainant states that between April 2008 and July 2008, Complainant used Respondent to ship apparel goods from Karachi, Pakistan to the United States for delivery to Ambition Apparel, Inc., hereinafter ''Buyer.'' Complainant further states that Respondent released four containers of apparel to Buyer without being presented an original house bill of lading and without Complainant's consent. Complainant asserts that no payment has been received from Buyer for the shipped goods and control of the goods has been lost. Complainant contends that Respondent's actions violated the Shipping Act of 1984, as amended, by failing to establish, observe, and enforce just and reasonable regulations and practices relating to or connected with receiving, handling, storing, or delivering property. 46 U.S.C. 41102(c).

Respondent states that Complainant has agreed not to contest this Complaint in order to allow Complainant to secure the release of FMC Bond No. 18084F, in partial payment of the total damages incurred by Complainant. Complainant requests that the Commission issue an order for reparations in favor of Complainant and against Respondent, in the amount of $342,070.80, and that the Commission grant such other, proper, and further relief, in accordance with its delegated powers, as it may deem just, proper, and equitable in the circumstances.

This proceeding has been assigned to the Office of the Administrative Law Judges. Pursuant to the Commission's Rules of Practice and Procedure, 46 CFR 502.181 (Subpart K—Shortened Procedure) Complainant has requested that its complaint be handled on an expedited basis. Under this procedure, with the consent of the parties and with the approval of the presiding officer, this proceeding may be conducted under shortened procedure without oral hearing, except that a hearing may be ordered by the presiding officer at the request of either party to the proceeding or at the presiding officer's discretion. Within 25 days of the date of service of the complaint, Respondent shall, if they consent to the shortened procedure, file with the Commission and serve on the Complainant, its answering memorandum of facts and arguments relied upon. Within 15 days after the date of service of Respondent's answering memorandum, Complainant may file with the Commission and serve on the Respondent, their reply. This will close the record for decision unless the presiding officer orders the submission of additional evidentiary material. If Respondent does not consent to this shortened procedure, the matter will be governed by 46 CFR 502.61 (Subpart E—Proceedings, Pleadings, Motions, Replies). Pursuant to the further terms of 46 CFR 502.61, the initial decision of the presiding officer in this proceeding shall be issued by July 7, 2010, and the final decision of the Commission shall be issued by November 4, 2010.

Karen V. Gregory,

Secretary.

[FR Doc. E9–16428 Filed 7–10–09; 8:45 am]

BILLING CODE P

FEDERAL TRADE COMMISSION

Agency Information Collection Activities; Proposed Collection; Comment Request

AGENCY: Federal Trade Commission (FTC or Commission).

ACTION: Notice.

SUMMARY: The FTC seeks public comments on proposed information requests to depository institutions lacking federal deposit insurance. The FTC plans to use this information to help ensure that such institutions are complying with the disclosure requirements of the Federal Deposit Insurance Corporation Improvement Act (FDICIA). The FTC will consider comments before it submits a request for Office of Management and Budget (OMB) review under the Paperwork Reduction Act (PRA).

DATES: Comments must be received on or before September 14, 2009.

ADDRESSES: Interested parties are invited to submit written comments electronically or in paper form. Comments should refer to ''FDICIA Compliance Monitoring: Paperwork Comment; FTC File No. P094205'' to facilitate the organization of comments. Please note that your comment—including your name and your state—will be placed on the public record of this proceeding, including on the publicly accessible FTC Website, at (*http://www.ftc.gov/os/publiccomments.shtm*).

Because comments will be made public, they should not include any sensitive personal information, such as an individual's Social Security Number; date of birth; driver's license number or other state identification number, or foreign country equivalent; passport number; financial account number; or credit or debit card number. Comments also should not include any sensitive health information, such as medical records or other individually identifiable health information. In addition, comments should not include any ''[t]rade secret or any commercial or financial information which is obtained from any person and which is privileged or confidential. . . .,'' as provided in Section 6(f) of the Federal Trade Commission Act (FTC Act), 15 U.S.C. 46(f), and FTC Rule 4.10(a)(2), 16 CFR 4.10(a)(2). Comments containing material for which confidential treatment is requested must be filed in paper form, must be clearly labeled ''Confidential,'' and must comply with FTC Rule 4.9(c), 16 CFR 4.9(c).[1]

Because paper mail addressed to the FTC is subject to delay due to heightened security screening, please consider submitting your comments in electronic form. Comments filed in electronic form should be submitted by using the following weblink: (*https://secure.commentworks.com/ftc-fdiciacompliance*) (and following the instructions on the web-based form). To ensure that the Commission considers an electronic comment, you must file it on the web-based form at the weblink (*https://secure.commentworks.com/ftc-fdiciacompliance*). If this Notice appears at (*http://www.regulations.gov/search/index.jsp*), you may also file an electronic comment through that website. The Commission will consider all comments that regulations.gov forwards to it. You may also visit the FTC Website at *http://www.ftc.gov* to read the Notice and the news release describing it.

A comment filed in paper form should include the ''FDICIA Compliance Monitoring: Paperwork Comment; FTC File No. P094205'' reference both in the text and on the envelope, and should be mailed or delivered to the following address: Federal Trade Commission, Office of the Secretary, Room H-135 (Annex J), 600 Pennsylvania Avenue, NW, Washington, DC 20580. The FTC is requesting that any comment filed in paper form be sent by courier or overnight service, if possible, because U.S. postal mail in the Washington area and at the Commission is subject to delay due to heightened security precautions.

The FTC Act and other laws the Commission administers permit the collection of public comments to consider and use in this proceeding as appropriate. The Commission will consider all timely and responsive public comments that it receives, whether filed in paper or electronic form. Comments received will be available to the public on the FTC Website, to the extent practicable, at (*http://www.ftc.gov/os/publiccomments.shtm*). As a matter of discretion, the Commission makes every effort to remove home contact information for individuals from the public comments it receives before

[1] The comment must be accompanied by an explicit request for confidential treatment, including the factual and legal basis for the request, and must identify the specific portions of the comment to be withheld from the public record. The request will be granted or denied by the Commission's General Counsel, consistent with applicable law and the public interest. *See* FTC Rule 4.9(c), 16 CFR 4.9(c).

placing those comments on the FTC Website. More information, including routine uses permitted by the Privacy Act, may be found in the FTC's privacy policy, at (*http://www.ftc.gov/ftc/privacy.shtm*).

FOR FURTHER INFORMATION CONTACT: Hampton Newsome, Attorney, 202-326-2889, Division of Enforcement, Bureau of Consumer Protection, Federal Trade Commission.

SUPPLEMENTARY INFORMATION: In 1991, Congress enacted section 43 of FDICIA (12 U.S.C. 1831t) in response to incidents affecting the safety of deposits in certain financial institutions.[2] The law imposes several requirements on non-federally insured institutions. Among other things, the law (12 U.S.C. 1831t(b)) mandates that depository institutions lacking federal deposit insurance disclose to consumers, in periodic statements and advertising, that the institution does not have federal deposit insurance and that, if the institution fails, the federal government does not guarantee that depositors will get their money back. Pursuant to 12 U.S.C. 1831t(f), the Commission has authority to enforce the disclosure requirements under the FTC Act (15 U.S.C. 41 *et seq.*).

Until 2003, the Commission's appropriations authority prohibited the use of FTC resources to enforce those requirements.[3] In 2005, the Commission sought public comment on proposed rules implementing the statutory disclosure requirements.[4] In 2006, before the Commission issued a final rule, Congress passed substantial amendments to the existing requirements as part of the Financial Services Regulatory Relief Act of 2006 (FSRRA) (Pub. L. 109-351). The Commission, therefore, is currently seeking comment on proposed regulations that are consistent with the FSRRA amendments.[5] Nevertheless, institutions lacking federal deposit insurance must comply with these statutory disclosure provisions regardless of the status of the FTC's regulations in this area.

Under existing law, all federally chartered and most state chartered depository institutions have federal deposit insurance. Federal deposit insurance provides a government guarantee of up to $250,000 per depositor in most cases. Pursuant to Federal Deposit Insurance Corporation and National Credit Union Administration requirements, federally insured banks and credit unions must display signs that depositors are federally insured.[6] Although most depository institutions have federal deposit insurance, there are some exceptions. For instance, there are more than a hundred and fifty state-chartered credit unions in nine states that do not have federal deposit insurance.[7] The credit unions in these states generally obtain private deposit insurance in lieu of federal insurance to protect members' accounts.

Proposed Information Collection Activities

The FTC has the authority to compel production of data and information from depository institutions lacking federal deposit insurance under Section 6(b) of the FTC Act, 15 U.S.C. 46(b). The Commission intends to send information requests to depository institutions that lack federal deposit insurance. The responses will help the Commission determine whether covered entities are complying with the disclosures required by 12 U.S.C. 1831t(b). Because the number of entities affected by the Commission's requests will exceed nine, the Commission plans to seek OMB clearance under the PRA, 44 U.S.C. Ch. 35.

Under the PRA, federal agencies must obtain approval from OMB for each collection of information they conduct or sponsor. ''Collection of information'' means agency requests or requirements that members of the public submit reports, keep records, or provide information to a third party. 44 U.S.C. 3502(3), 5 CFR 1320.3(c). As required by section 3506(c)(2)(A) of the PRA, the FTC is providing this opportunity for public comment before requesting that OMB grant the clearance for the proposed information collection.

The FTC invites comments on: (1) whether the proposed collections of information are necessary for the proper performance of the functions of the FTC, including whether the information will have practical utility; (2) the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) ways to minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology (*e.g.*, permitting electronic submission of responses). All comments should be filed as prescribed in the **ADDRESSES** section above, and must be received on or before September 14, 2009.

A. Description of the Collection of Information and Proposed Use

The FTC proposes to send information requests to up to two hundred (200) depository institutions lacking federal deposit insurance in the United States (''industry members''). State-chartered credit unions lacking federal deposit insurance will likely be the recipients.[8]

The information requests[9] will seek, among other things:

- A brief explanation of the steps the institution takes to comply with the requirements of 12 U.S.C. 1831t(b).
- Samples of each non-identical periodic statement of account, signature card, passbook, certificate of deposit, and share certificate that must contain the notice required by 12 U.S.C. 1831t(b)(1). None of the samples should include any individual consumer

[2] *See* Pub. L. No. 102-242, 105 Stat. 2236.

[3] Making Appropriations for Agriculture, Rural Development, Food and Drug Administration, and Related Agencies, for the Fiscal Year Ending September 30, 2004, and for Other Purposes, H.R. Conf. Rep. No. 108-401, 108th Cong., 1st Sess., at 88 (2003).

[4] *See* 70 FR 12823 (Mar. 16, 2005).

[5] *See* 74 FR 18043 (Mar. 13, 2009).

[6] *See* 12 CFR Parts 328 and 740.

[7] According to the U.S. Government Accountability Office, in 2003, eight states had credit unions that purchase private deposit insurance instead of federal insurance. Since that time, at least one additional state has allowed credit unions to use private deposit insurance. Other states either require federal insurance or allow private insurance but do not have any privately insured credit unions. ''Federal Deposit Insurance Act: FTC Best Among Candidates to Enforce Consumer Protection Provisions,'' GAO-03-971 (Aug. 2003), at 7. Puerto Rican credit unions operate under a Puerto Rican government-backed deposit insurance system.

[8] The FTC does not plan to send requests to institutions covered by the Puerto Rican government deposit insurance system.

[9] Section 6(f) of the FTC Act, 15 U.S.C. 46(f), bars the Commission from publicly disclosing trade secrets or confidential commercial or financial information it receives from persons pursuant to, among other methods, special orders authorized by Section 6(b) of the FTC Act. Such information also would be exempt from disclosure under the Freedom of Information Act. 5 U.S.C. 552(b)(4). Moreover, under Section 21(c) of the FTC Act, 15 U.S.C. 57b-2(c), a submitter who designates a submission as confidential is entitled to 10 days' advance notice of any anticipated public disclosure by the Commission, assuming that the Commission has determined that the information does not, in fact, constitute 6(f) material. Although materials covered under one or more of these various sections are protected by stringent confidentiality constraints, the FTC Act and the Commission's rules authorize disclosure in limited circumstances (*e.g.*, official requests by Congress, requests from other agencies for law enforcement purposes, and administrative or judicial proceedings). Even in those limited contexts, however, the Commission's rules may afford protections to the submitter, such as advance notice to seek a protective order in litigation. *See* 15 U.S.C. 57b-2; 16 CFR 4.9-4.11.

names, signatures, addresses, account numbers, or any other personally identifying information.

● Information (*e.g.* photographs) that demonstrates that the institution posts the disclosure required by 12 U.S.C. 1831t(b)(2) at each station or window where it normally receives deposits, the institution's principal place of business, and all the institution's branches where it accepts deposits or opens accounts (excluding automated teller machines and point of sale terminals).

● Copies of all non-identical advertising[10] issued or continued in use within the previous three months.

● Samples of the cards, forms, or other written materials the institution uses to comply with the signed acknowledgment requirements for new depositors pursuant to 12 U.S.C. 1831t(b)(3). The samples should not include any individual consumer names, signatures, addresses, account numbers, or any other personally identifying information.[11]

The Commission will use the collected information in its efforts to ensure that the institutions are complying with the disclosures required by the 12 U.S.C. 1831t(b).[12]

B. Estimated Hours Burden

Based upon its knowledge of the industry, the staff estimates, on average, that the time required to gather, organize, format, and produce such responses will average 8 hours per information request. Thus, allowing up to 200 recipients of the information requests, total burden would be approximately 1,600 hours.

C. Estimated Cost Burden

It is difficult to calculate with precision the labor costs associated with this data production, as they entail varying compensation levels of management and/or support staff among companies of different sizes. Managerial, legal, and clerical personnel may be involved in the information collection process. The FTC staff has assumed, conservatively, that managerial personnel and legal counsel will handle all of the tasks involved in gathering and producing responsive information, and has applied an average hourly wage of managerial time of $58.12/hour (4 hours per entity) and an average hourly wage of legal staff time of $40.87/hour (4 hours per entity).[13] Thus, cumulatively, estimated labor costs for the information requests will be $79,192 (($58.12 x 800 hours + $40.87 x 800 hours)). The actual cost may be lower to the extent clerical personnel handle some of the tasks.

FTC staff estimates that the capital or other non-labor costs associated with the information requests are minimal. We expect that industry members maintain most, if not all, of the requested material in the normal course of business because they must disclose the information to customers under existing law.

By direction of the Commission.

Donald S. Clark

Secretary

[FR Doc. E9–16518 Filed 7–10–09: 8:45 am]

BILLING CODE: 6750 –01–S

[10] As used in these requests, the term ''advertising'' means any communication that the institution uses to solicit business including, but not limited to, printed materials, the institution's main internet page, radio advertisements, video advertisements disseminated via television, the Internet or any other means of online communication, and solicitations conducted via telephone.

[11] The requested documents should exclude any information for which prior customer authorization is required under the Right to Financial Privacy Act, 12 U.S.C. 3401, *et seq.*

[12] Although the Commission is currently in the process of developing regulations for these requirements, *see* 74 FR 18043 (Mar. 13, 2009), institutions lacking federal deposit insurance must comply with these statutory provisions regardless of the status of FTC's regulations in this area.

[13] Hourly wages are averages based on mean hourly wages shown in *http://www.bls.gov/oes/2008/may/naics4_551100.htm#b11-0000* (May 2008 ''National Industry-Specific Occupational Employment and Wage Estimates'') for sales and marketing managers and legal occupations (lawyers, paralegals, and other legal support), respectively.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Toxicology Program (NTP); NTP Interagency Center for the Evaluation of Alternative Toxicological Methods (NICEATM); Independent Scientific Peer Review Panel Report: Evaluation of the Validation Status of Alternative Ocular Safety Testing Methods and Approaches: Notice of Availability and Request for Public Comments

AGENCY: National Institute of Environmental Health Sciences (NIEHS), National Institutes of Health (NIH).

ACTION: Request for comments.

SUMMARY: NICEATM, in collaboration with the Interagency Coordinating Committee on the Validation of Alternative Methods (ICCVAM), convened an independent international scientific peer review panel (hereafter, Panel) on May 19–21, 2009, to evaluate test methods and approaches with the potential to reduce and refine the use of animals for ocular safety testing. These evaluations included the following:

- A proposal for the routine use of topical anesthetics, systemic analgesics, and humane endpoints to avoid and minimize pain and distress during in vivo ocular irritation testing.
- The in vivo low volume eye test (LVET).
- The use of the bovine corneal opacity and permeability (BCOP), the Cytosensor Microphysiometer® (CM), the isolated chicken eye (ICE), the isolated rabbit eye (IRE), and the hen's egg test—chorioallantoic membrane (HET–CAM) test methods for identifying moderate and mild ocular irritants and substances not labeled as ocular irritants.
- Nonanimal testing strategies that use the BCOP, CM, and/or EpiOcular™ (EO) test methods to assess the eye irritation potential of antimicrobial cleaning products to determine their appropriate U.S. Environmental Protection Agency ocular hazard classification.

The Panel report from this meeting is now available. The report contains (1) The Panel's evaluation of the validation status of the test methods and testing strategies and (2) the Panel's comments on the draft ICCVAM test method recommendations. NICEATM invites public comment on the Panel report. The report is available on the NICEATM–ICCVAM Web site at *http://iccvam.niehs.nih.gov/docs/ocutox_docs/OcularPRPRept2009.pdf* or by contacting NICEATM at the address given below.

DATES: Written comments on the Panel report should be received by August 28, 2009.

ADDRESSES: NICEATM prefers that comments be submitted electronically by e-mail to *niceatm@niehs.nih.gov.* Comments can also be submitted via the NICEATM–ICCVAM Web site at *http://iccvam.niehs.nih.gov/contact/FR_pubcomment.htm.* Written comments can be sent by mail or fax to Dr. William S. Stokes, Director, NICEATM, NIEHS, P.O. Box 12233, Mail Stop: K2–16, Research Triangle Park, NC 27709; (fax) 919–541–0947. Courier address: NIEHS, NICEATM, 530 Davis Drive, Room 2035, Durham, NC 27713.

FOR FURTHER INFORMATION CONTACT: Dr. William S. Stokes, (telephone) 919–541–2384, (fax) 919–541–0947 and (e-mail) *niceatm@niehs.nih.gov.*

SUPPLEMENTARY INFORMATION:

Background

NICEATM announced the convening of an independent scientific peer review

panel to review and comment on the draft background review documents (BRDs) and summary review documents (SRDs) and draft recommendations, as well as the availability of the draft documents for public comment, in March 2009 (74 FR 14556). The Panel met in public session on May 19–21, 2009, at Consumer Product Safety Commission Headquarters in Bethesda, MD. The Panel reviewed the draft ICCVAM documents for completeness, errors, and omissions of any existing relevant data or information. The Panel then evaluated the information in the draft documents to determine the extent to which each of the applicable criteria for validation and acceptance of toxicological test methods (ICCVAM 2003) had been appropriately addressed. The Panel then considered the ICCVAM draft recommendations and commented on the extent that the recommendations were supported by the information provided in the draft BRDs or SRDs.

ICCVAM organized a 2005 symposium (70 FR 18037) on Minimizing Pain and Distress in Ocular Toxicity Testing where experts recommended that topical anesthetics and systemic analgesics should be routinely administered before in vivo ocular safety testing to avoid or minimize pain and distress that might occur during and after the initial application of test substances. The experts also recommended that systemic analgesics should routinely be administered when there are clinical signs indicative of pain or distress. The experts further recommended that humane endpoints to end a study early should be identified and used routinely. ICCVAM requested data (72 FR 26396), compiled available information on the use of topical anesthetics, systemic analgesics, and humane endpoints during in vivo ocular safety testing, and developed draft recommendations for implementing such practices.

In 2007, ICCVAM published (70 FR 66451) recommendations on the use of four in vitro test methods (BCOP, ICE, IRE, HET–CAM) for identifying ocular corrosives and severe irritants for hazard classification and labeling purposes. The ICCVAM recommendations were submitted to and accepted by ICCVAM member agencies (more information at *http://iccvam.niehs.nih.gov/methods/ocutox/ivocutox/ocu_recommend.htm*). One of the ICCVAM recommendations was to consider the validation status of these four in vitro ocular test methods for identifying mild and moderate ocular irritants and substances not classified as ocular irritants. NICEATM and ICCVAM requested data (72 FR 31582), compiled available information, prepared draft BRDs assessing their current validation status for this purpose, and developed draft recommendations for their use.

In January 2008, a BRD titled, An In Vitro Approach for EPA Labeling of Anti-Microbial Cleaning Products, was submitted to NICEATM for review. This BRD, prepared by the Institute for In Vitro Sciences in collaboration with the Alternative Testing Working Group (comprised of seven consumer product companies [Clorox, Colgate Palmolive, Dial, EcoLabs, Johnson Diversey, Procter and Gamble, and SC Johnson]), proposes a testing strategy that uses the CM®, EpiOcular™, and BCOP test methods to assess the eye irritation potential of antimicrobial cleaning products and to determine appropriate EPA ocular hazard classification categories for such products. NICEATM and ICCVAM reviewed the BRD, requested additional data and information (73 FR 18535), and compiled draft recommendations and a draft ICCVAM SRD. ICCVAM also reviewed the validation status of the LVET, which is proposed as a reference test method to partially substantiate the validity of the in vitro test methods used in the test strategy.

Availability of the Peer Panel Report

The Panel's conclusions and recommendations are detailed in the Independent Scientific Peer Review Panel Report: Evaluation of the Validation Status of Alternative Ocular Safety Testing Methods and Approaches which is available along with the draft documents reviewed by the Panel and the draft ICCVAM test method recommendations at *http://iccvam.niehs.nih.gov/methods/ocutox/PeerPanel09.htm.*

Request for Public Comments

NICEATM invites the submission of written comments on the Panel report. When submitting written comments, please refer to this **Federal Register** notice and include appropriate contact information (name, affiliation, mailing address, phone, fax, e-mail, and sponsoring organization, if applicable). All comments received will be made publicly available via the NICEATM–ICCVAM Web site at *http://iccvam.niehs.nih.gov/methods/ocutox/PeerPanel09.htm*. ICCVAM will consider the Panel report along with public comments and comments made by the Scientific Advisory Committee on Alternative Toxicological Methods (SACATM) at their June 25–26, 2009 meeting (74 FR 19562) when finalizing test method recommendations. Final ICCVAM recommendations will be published in ICCVAM test method evaluation reports, which will be forwarded to relevant Federal agencies for their consideration. The evaluation reports will also be available to the public on the NICEATM–ICCVAM Web site at *http://iccvam.niehs.nih.gov/methods/ocutox/ocutox.htm* and by request from NICEATM (see **ADDRESSES** above).

Background Information on ICCVAM, NICEATM, and SACATM

ICCVAM is an interagency committee composed of representatives from 15 Federal regulatory and research agencies that use, generate, or disseminate toxicological information. ICCVAM conducts technical evaluations of new, revised, and alternative methods with regulatory applicability, and promotes the scientific validation and regulatory acceptance of toxicological test methods that more accurately assess the safety and hazards of chemicals and products and that refine, reduce, and replace animal use. The ICCVAM Authorization Act of 2000 (42 U.S.C. 285l–3) established ICCVAM as a permanent interagency committee of the NIEHS under NICEATM. NICEATM administers ICCVAM and provides scientific and operational support for ICCVAM-related activities. NICEATM and ICCVAM work collaboratively to evaluate new and improved test methods applicable to the needs of U.S. Federal agencies. Additional information about ICCVAM and NICEATM can be found on their Web site (*http://iccvam.niehs.nih.gov).*

SACATM was established January 9, 2002, and is composed of scientists from the public and private sectors (67 FR 11358). SACATM provides advice to the Director of the NIEHS, ICCVAM, and NICEATM regarding the statutorily mandated duties of ICCVAM and activities of NICEATM. Additional information about SACATM, including the charter, roster, and records of past meetings, can be found at *http://ntp.niehs.nih.gov/* see ''Advisory Board & Committees'' (or directly at *http://ntp.niehs.nih.gov/go/167*).

Reference

ICCVAM. 2003. ICCVAM Guidelines for the Nomination and Submission of New, Revised, and Alternative Test Methods. NIH Publication No. 03–4508. Research Triangle Park, NC: NIEHS. Available at: *http://iccvam.niehs.nih.gov.*

Dated: July 3, 2009.

John R. Bucher,

Associate Director, NTP.

[FR Doc. E9–16388 Filed 7–10–09; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Agency Information Collection Activities: Proposed Collection; Comment Request

In compliance with Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 concerning opportunity for public comment on proposed collections of information, the Substance Abuse and Mental Health Services Administration (SAMHSA) will publish periodic summaries of proposed projects. To request more information on the proposed projects or to obtain a copy of the information collection plans, call the SAMHSA Reports Clearance Officer on (240) 276–1243.

Comments are invited on: (a) Whether the proposed collections of information are necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology.

Proposed Project: 2009 Survey of Revenues and Expenditures (SRE)—NEW

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) will conduct a 2009 SRE. This national survey represents a survey of mental health and substance abuse treatment facilities. These separate service locations are called facilities, in contrast to mental health and substance abuse organizations, which may include multiple facilities (service locations). This survey will be a sample survey of all known mental health and substance abuse treatment facilities nationwide with a particular focus on revenues and expenditures. The survey will begin with a stratified random sample of 1,500 facilities drawn from other SAMHSA databases. In addition, a control subsample of 100 facilities drawn from the original 1,500 will be drawn and pursued beyond the planned three follow-up attempts with the entire sample. The control sample will provide estimates of non-response bias upon the results of the data analyses.

The 2009 SRE will utilize one questionnaire for all mental health and substance abuse treatment facility types including hospitals, residential treatment centers and outpatient clinics. The information collected will include annual revenue and expenditures, staffing, and active caseload size. All treatment facilities will have the option of completing the survey instrument online via the Internet, by telephone with an interviewer, or using a paper version of the questionnaire.

The resulting database will be used for national estimates of facility types, their revenues and expenditures, and their patient caseloads. These findings will be used to update SAMHSA's national spending on mental health and substance abuse treatment estimates. The survey results will be published by CMHS in *Data Highlights,* in *Mental Health, United States,* and in professional journals such as *Psychiatric Services* and the *American Journal of Psychiatry.* The publication *Mental Health, United States* is used by the general public, State governments, the U.S. Congress, university researchers, and other health care professionals. The following Table summarizes the estimated response burden for the survey.

	Number of respondents	Responses per respondent	Average hours per response	Total hour burden
Treatment facilities	1,500	1	2.5	3,750

Send comments to Summer King, SAMHSA Reports Clearance Officer, Room 7–1044, One Choke Cherry Road, Rockville, MD 20857. Written comments should be received within 60 days of this notice.

Dated: July 2, 2009.

Elaine Parry,

Director, Office of Program Services.

[FR Doc. E9–16459 Filed 7–10–09; 8:45 am]

BILLING CODE 4162–20–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Agency Information Collection Activities: Submission for OMB Review; Comment Request

Periodically, the Substance Abuse and Mental Health Services Administration (SAMHSA) will publish a summary of information collection requests under OMB review, in compliance with the Paperwork Reduction Act (44 U.S.C. Chapter 35). To request a copy of these documents, call the SAMHSA Reports Clearance Officer on (240) 276–1243.

Proposed Project: SAMHSA Fetal Alcohol Spectrum Disorders Center for Excellence Project CHOICES Evaluation—New

Since 2001, SAMHSA's Center for Substance Abuse Prevention has been operating the SAMHSA Fetal Alcohol Spectrum Disorders (FASD) Center for Excellence. The purpose of the FASD Center for Excellence is to prevent and improve the treatment of FASD. Some of the activities of the FASD Center include providing training, technical assistance, and subcontracts to increase the use of effective evidence-based interventions.

The FASD Center will be integrating the Project CHOICES program through service delivery organizations and will be evaluating the results. Six sites will implement Project CHOICES with nonpregnant women 18–44 years who are sexually active and who are participating in alcohol treatment

(residential or outpatient) or in drug treatment (if the women also use alcohol). Women in substance abuse treatment will be screened and those women that meet the above description will be provided four Motivational Interviewing (MI) sessions (related to alcohol use), plus one contraceptive counseling session. The goal is to help these women prevent an alcohol-exposed pregnancy by abstaining from alcohol and using contraceptive methods of their choice consistently and correctly.

At baseline, an assessment tool will be administered by the counselor to assess drinking, sexual activity, contraceptive use, and demographic information. At the end of the program, women are assessed on their alcohol consumption and contraceptive use in the past 30 days. At 6 months and 12 months after the end of the program, women are assessed on alcohol consumption and contraceptive use using the same core assessment tool used at baseline. All participating sites will maintain personal identification on their clients for service delivery purposes but no such information will be transmitted to SAMHSA.

The data collection is designed to evaluate the implementation of Project CHOICES by measuring whether abstinence from alcohol is achieved and effective birth control practices are performed. Furthermore, the project will include process measures to assess whether and how the intervention was provided.

ESTIMATED ANNUALIZED BURDEN HOURS

Screening tool/activity	Number of respondents (6 sites)	Number of responses per respondent	Average burden per response	Total burden hours per collection
Alcohol Use and Contraceptive Methods Assessment (Screening Form/ Form Q)	913	1	0.25	228
Project CHOICES process evaluation assessing whether sessions were delivered and their duration (4 MI sessions and 1 contraception use session—Form B and C—75% of baseline)	684	5	0.08	274
Alcohol Use and Contraceptive Methods Assessment: End of program, 6- and 12-month followup (Forms D, E, & F—50% of baseline)	456	3	0.25	342
Total	2,053			844

Written comments and recommendations concerning the proposed information collection should be sent by August 12, 2009 to: SAMHSA Desk Officer, Human Resources and Housing Branch, Office of Management and Budget, New Executive Office Building, Room 10235, Washington, DC 20503; due to potential delays in OMB's receipt and processing of mail sent through the U.S. Postal Service, respondents are encouraged to submit comments by fax to: 202–395–6974.

Dated: July 2, 2009.

Elaine Parry,

Director, Office of Program Services.

[FR Doc. E9–16458 Filed 7–10–09; 8:45 am]

BILLING CODE 4162–20–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Proposed Information Collection Activity; Comment Request

Proposed Projects:

Title: Child Care and Development Fund Financial Report (ACF 696) for States and Territories.

OMB No.: 0970–0163.

Description: States and Territories use the Financial Report Form ACF–696 to report Child Care and Development Fund (CCDF) expenditures. Authority to collect and report this information is found in section 658G of the Child Care and Development Block Grant Act of 1990, as revised. In addition to the Program Reporting Requirements set forth in 45 CFR part 98, Subpart H, the regulations at 45 CFR 98.65(g) and 98.67(c)(1) authorize the Secretary to require financial reports as necessary.

The form provides specific data regarding claims and provides a mechanism for States to request Child Care grant awards and to certify the availability of State matching funds. Failure to collect this data would seriously compromise ACF's ability to monitor Child Care and Development Fund expenditures. This information is also used to estimate outlays and may be used to prepare ACF budget submissions to Congress.

The American Recovery and Reinvestment Act (ARRA) of 2009, (Pub. L. 111–5) provides an additional $2 billion for the Child Care and Development Fund to help States, Territories, and Tribes provide child care assistance to low income working families. CCDF Program Instruction (CCDF-ACF-PI–2009–03) provided guidance on ARRA spending requirements.

Section 1512 of the ARRA legislation requires recipients to report quarterly spending and performance data on the public Web site, ''Recovery.gov.'' Federal agencies are required to collect ARRA expenditure data and performance data and these data must be clearly distinguishable from the regular CCDF (non-ARRA) funds. To ensure transparency and accountability, the ARRA authorizes Federal agencies and grantees to track and report separately on expenditures from funds made available by the stimulus bill. Office of Management and Budget (OMB) guidance implementing the ARRA legislation indicates that agencies requiring additional information for oversight should rely on existing authorities and reflect these requirements in their award terms and conditions as necessary, following existing procedures. Therefore, to capture ARRA expenditures, the ACF–696 has been modified (by the addition of a column) for reporting ARRA expenditure data. In addition, a new data element will ask States and Territories to estimate the number of child service months funded with ARRA dollars. The collection will not duplicate other information.

Respondents: States and Territories.

ANNUAL BURDEN ESTIMATES

Instrument	Number of respondents	Number of responses per respondent	Average burden hours per response	Total burden hours
ACF–696	56	4	5	1,120.

Estimated Total Annual Burden Hours: 1,120.

In compliance with the requirements of Section 506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Administration for Children and Families is soliciting public comment on the specific aspects of the information collection described above. Copies of the proposed collection of information can be obtained and comments may be forwarded by writing to the Administration for Children and Families, Office of Administration, Office of Information Services, 370 L'Enfant Promenade, SW., Washington, DC 20447, Attn: ACF Reports Clearance Officer. E-mail address: *infocollection@acf.hhs.gov*. All requests should be identified by the title of the information collection.

The Department specifically requests comments on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Consideration will be given to comments and suggestions submitted within 60 days of this publication.

Dated: July 8, 2009.

Janean Chambers,

Reports Clearance Officer.

[FR Doc. E9–16508 Filed 7–10–09; 8:45 am]

BILLING CODE 4184–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Proposed Information Collection Activity; Comment Request

Proposed Projects:

Title: Child Care and Development Fund Annual Financial Report (ACF–696T) for Tribes.

OMB No.: 0970–0195.

Description: Tribes use the Financial Report Form ACF–696T to report Child Care and Development Fund (CCDF) expenditures. Authority to collect and report this information is found in Section 658G of the Child Care and Development Block Grant Act of 1990, as revised. In addition to the Program Reporting Requirements set forth in 45 CFR part 98, Subpart H, the regulations at 45 CFR 98.65(g) and 98.67(c)(1) authorize the Secretary to require financial reports as necessary.

Tribal grantees submit the ACF–696T report on an annual basis on behalf of the Tribal Lead Agency administering the Child Care and Development Fund (CCDF).

The American Recovery and Reinvestment Act (ARRA) of 2009, (Pub. L. 111–5) provides an additional $2 billion for the Child Care and Development Fund to help States, Territories, and Tribes provide child care assistance to low income working families. CCDF Program Instruction (CCDF–ACF–PI–2009–03) provided guidance on ARRA spending requirements.

Section 1512 of the ARRA legislation requires recipients to report quarterly spending and performance data on the public Web site, ''Recovery.gov.'' Federal agencies are required to collect ARRA expenditure data and performance data and these data must be clearly distinguishable from the regular CCDF (non-ARRA) funds. To ensure transparency and accountability, the ARRA requires Federal agencies and grantees to track and report separately on expenditures from funds made available by the stimulus bill. Office of Management and Budget (OMB) guidance implementing the ARRA legislation indicates that agencies requiring additional information for oversight should rely on existing authorities and reflect these requirements in their award terms and conditions as necessary, following existing procedures. Therefore, to capture ARRA expenditures, the ACF–696T has been modified (by the addition of two columns) for reporting ARRA data. In addition, a new data element will ask Tribes to estimate the number of child service months funded with ARRA dollars. The collection will not duplicate other information.

Respondents: Tribes and tribal organizations that are CCDF grantees.

ANNUAL BURDEN ESTIMATES

Instrument	Number of respondents	Number of responses per respondent	Average burden hours per response	Total burden hours
ACF–696T CCDF Financial Reporting Form for Tribes	232	1	8	1,856

Estimated Total Annual Burden Hours: 1,856.

In compliance with the requirements of Section 506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Administration for Children and Families is soliciting public comment on the specific aspects of the information collection described above. Copies of the proposed collection of information can be obtained and comments may be forwarded by writing to the Administration for Children and Families, Office of Administration, Office of Information Services, 370 L'Enfant Promenade, SW., Washington, DC 20447, Attn: ACF Reports Clearance Officer. E-mail address: *infocollection@acf.hhs.gov.* All requests should be identified by the title of the information collection.

The Department specifically requests comments on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have

practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Consideration will be given to comments and suggestions submitted within 60 days of this publication.

Dated: July 8, 2009.

Janean Chambers,

Reports Clearance Officer.

[FR Doc. E9–16505 Filed 7–10–09; 8:45 am]

BILLING CODE 4184–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Notice of Hearing: Reconsideration of Disapproval of Washington State Plan Amendment (SPA) 08–019

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice of hearing.

SUMMARY: This notice announces an administrative hearing to be held on August 4, 2009 at the CMS Seattle Regional Office, 2201 Sixth Avenue, MS/RX–43, Seattle, Washington 98121, to reconsider CMS' decision to disapprove Washington SPA 08–019.

Closing Date: Requests to participate in the hearing as a party must be received by the presiding officer by July 28, 2009.

FOR FURTHER INFORMATION CONTACT: Benjamin Cohen, Presiding Officer, CMS, 2520 Lord Baltimore Drive, Suite L, Baltimore, Maryland 21244, Telephone: (410) 786–3169.

SUPPLEMENTARY INFORMATION:

This notice announces an administrative hearing to reconsider CMS' decision to disapprove Washington SPA 08–019 which was received by CMS on September 23, 2008, and disapproved on March 6, 2009. The SPA proposed to increase dispensing fees for pharmacies from $4.20 to $4.24 for high-volume pharmacies, $4.51 to $4.56 for mid-volume pharmacies, $5.20 to $5.25 for low-volume pharmacies, and $5.20 to $5.25 for unit dose systems.

As submitted, SPA 08–019 has raised concerns regarding compliance with section 1902(a)(30) of the Social Security Act (the Act) and implementing regulatory requirements. Section 1902(a)(30)(A) of the Act requires that States have methods and procedures in place to assure that payments are consistent with efficiency, economy, and quality of care. Under that authority, the Secretary has issued regulations prescribing State rate-setting procedures and requirements. Longstanding requirements (presently codified at 42 CFR 447.512 and 447.514, and previously codified at 42 CFR 447.331 and 447.332) provide that the State is responsible for demonstrating that the dispensing fees are reasonable. The State has not provided that demonstration. In addition, Federal regulations at 42 CFR 447.205 require that a State provide public notice of any significant proposed change in its methods and standards for setting payment rates for services. In support of this amendment, the State believes that issuing a memorandum to providers online meets the public requirements. We believe that this does not meet the Federal standard. We believe public notice promotes transparency and openness in this process and allows the public to be fully aware of the State's actions.

Based on the above, and after consultation with the Secretary of the Department of Health and Human Services as required under Federal regulations at 42 CFR 430.15(c)(2), Washington SPA 08–019 was disapproved.

The following issues will be considered at the hearing:

- Whether Washington provided adequate public notice for setting payment rates for services as required at 42 CFR 447.205.
- Whether Washington met the longstanding requirement (presently codified at 42 CFR 447.512 and 447.514, and previously codified in 42 CFR 447.331 and 447.332) that the State is responsible for demonstrating that the proposed increased dispensing fees are reasonable.

Section 1116 of the Act and Federal regulations at 42 CFR Part 430, establish Department procedures that provide an administrative hearing for reconsideration of a disapproval of a State plan or plan amendment. CMS is required to publish a copy of the notice to a State Medicaid agency that informs the agency of the time and place of the hearing, and the issues to be considered. If CMS subsequently notifies the agency of additional issues that will be considered at the hearing, we will also publish that notice.

Any individual or group that wants to participate in the hearing as a party must petition the presiding officer within 15 days after publication of this notice, in accordance with the requirements contained at 42 CFR 430.76(b)(2). Any interested person or organization that wants to participate as amicus curiae must petition the presiding officer before the hearing begins in accordance with the requirements contained at 42 CFR 430.76(c). If the hearing is later rescheduled, the presiding officer will notify all participants.

The notice to the State of Washington announcing an administrative hearing to reconsider the disapproval of its SPA reads as follows:

Ms. Susan Dreyfus, Secretary, Department of Social and Health Services, P.O. Box 45010, Olympia, WA 98504–5010.

Dear Ms. Dreyfus: I am responding to your request for reconsideration of the decision to disapprove the Washington State plan amendment (SPA) 08–019, which was received by the Centers for Medicare & Medicaid Services on September 23, 2008, and disapproved on March 6, 2009. The SPA proposed to increase dispensing fees for pharmacies from $4.20 to $4.24 for high-volume pharmacies, $4.51 to $4.56 for mid-volume pharmacies, $5.20 to $5.25 for low-volume pharmacies, and $5.20 to $5.25 for unit dose systems.

The following issues will be considered at the hearing:

- Whether Washington provided adequate public notice for setting payment rates for services as required at 42 CFR 447.205.
- Whether Washington met the longstanding requirement (presently codified at 42 CFR 447.512 and 447.514, and previously codified in 42 CFR 447.331 and 447.332) that the State is responsible for demonstrating that the proposed increased dispensing fees are reasonable.

I am scheduling a hearing on your request for reconsideration to be held on August 4, 2009, at the Centers for Medicare & Medicaid Services', Seattle Regional Office, 2201 Sixth Avenue, MS/RX–43, Seattle, Washington 98121, in order to reconsider the decision to disapprove SPA 08–019. If this date is not acceptable, we would be glad to set another date that is mutually agreeable to the parties. The hearing will be governed by the procedures prescribed by Federal regulations at 42 CFR Part 430.

I am designating Mr. Benjamin Cohen as the presiding officer. If these arrangements present any problems, please contact the presiding officer at (410) 786–3169. In order to facilitate any communication which may be necessary among the parties to the hearing, please notify the presiding officer to indicate acceptability of the hearing date that has been scheduled and provide names of the individuals who will represent the State at the hearing.

Sincerely,

Charlene Frizzera,

Acting Administrator.

Section 1116 of the Social Security Act (42 U.S.C. 1316; 42 CFR 430.18)

(Catalog of Federal Domestic Assistance program No. 13.714, Medicaid Assistance Program)

Dated: June 16, 2009.

Charlene Frizzera,

Acting Administrator, Centers for Medicare & Medicaid Services.

[FR Doc. E9–16677 Filed 7–10–09; 8:45 am]

BILLING CODE P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Advisory Committee for Women's Services; Notice of Meeting

Pursuant to Public Law 92–463, notice is hereby given of a Web-based meeting of the Substance Abuse and Mental Health Services Administration (SAMHSA) Advisory Committee for Women's Services on July 29, 2009 from 2 p.m. to 4:30 p.m. The meeting is open to the public and will include an update on current and emerging research on women-specific substance use and mental health issues.

ACWS members and invited presenters will participate in this meeting through remote internet connection. On-site attendance by the public will be limited to space available. The meeting can also be accessed by the public via teleconference. To obtain teleconference call-in numbers and access codes, to make arrangements to attend on-site, or to request special accommodations for persons with disabilities, please communicate with Ms. Nevine Gahed, Designated Federal Official (see contact information below).

Substantive meeting information and a roster of Committee members may be obtained either by accessing the SAMHSA Committees' Web site at *https://nac.samhsa.gov/WomenServices/index.aspx*, or by contacting Ms. Gahed. The transcript for the meeting will also be available on the SAMHSA Committees' Web site within three weeks after the meeting.

Committee Name: SAMHSA Advisory Committee for Women's Services.

Date/Time/Type: Wednesday, July 29, 2009, from 2 p.m. to 4:30 p.m.: Open.

Place: 1 Choke Cherry Road, Sugarloaf Conference Room, Rockville, Maryland 20857.

Contact: Nevine Gahed, Designated Federal Official, SAMHSA Advisory Committee for Women's Services, 1 Choke Cherry Road, Room 8–1112, Rockville, Maryland 20857, Telephone: (240) 276–2331; FAX: (240) 276–2220 and E-mail: *nevine.gahed@samhsa.hhs.gov*.

Dated: July 6, 2009.

Toian Vaughn,

Committee Management Officer, Substance Abuse and Mental Health Services Administration.

[FR Doc. E9–16457 Filed 7–10–09; 8:45 am]

BILLING CODE 4162–20–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Disease, Disability, and Injury Prevention and Control Special Emphasis Panel (SEP): Capacity Building Assistance (CBA) To Improve the Delivery and Effectiveness of Human Immunodeficiency Virus (HIV) Prevention Services for High-Risk and/or Racial/Ethnicity Minority Populations, Program Announcement Number PS09–906, Initial Review

In accordance with Section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), the Centers for Disease Control and Prevention (CDC) announces the aforementioned meeting.

Time and Date: 8:30 a.m.–5:30 p.m., July 28, 2009 (Closed).

Place: CDC, Corporate Square Campus, 8 Corporate Boulevard, Atlanta, Georgia 30329.

Status: The meeting will be closed to the public in accordance with provisions set forth in Section 552b(c) (4) and (6), Title 5 U.S.C., and the Determination of the Director, Management Analysis and Services Office, CDC, pursuant to Public Law 92–463.

Matters To Be Discussed: The meeting will include an initial review, discussion, and evaluation of applications received in response to ''Capacity Building Assistance (CBA) to Improve the Delivery and Effectiveness of Human Immunodeficiency Virus (HIV) Prevention Services for High-Risk and/or Racial/Ethnicity Minority Populations, PS09–906.'' The meeting was initially held June 15–18, 2009. A reviewer conflict of interest was confirmed after the meeting commenced and a reviewer for another application was unable to participate due to sudden illness; therefore, the panel will be reconvened to review the affected applications.

Contact Person for More Information: Monica Farmer, M.Ed., Public Health Analyst, Strategic Science and Program Unit, Office of the Director, Coordinating Center for Infectious Diseases, CDC, 1600 Clifton Road, NE., Mailstop E–60, Atlanta, GA 30333, Telephone: (404) 498–2277.

The Director, Management Analysis and Services Office, has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities, for both CDC and the Agency for Toxic Substances and Disease Registry.

Dated: July 7, 2009.

Elaine L. Baker,

Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. E9–16460 Filed 7–10–09; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Disease, Disability, and Injury Prevention and Control Special Emphasis Panel (SEP): Strengthening National Capacity in Malaria and Other Infectious Disease Operations Research, Funding Opportunity Announcement (FOA) CK09–004, Initial Review

In accordance with Section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), the Centers for Disease Control and Prevention (CDC) announces the aforementioned meeting.

Time and Date: 2:30 p.m.–4:30 p.m., July 28, 2009 (Closed).

Place: Teleconference.

Status: The meeting will be closed to the public in accordance with provisions set forth in Section 552b(c) (4) and (6), Title 5 U.S.C., and the Determination of the Director, Management Analysis and Services Office, CDC, pursuant to Public Law 92–463.

Matters To Be Discussed: The meeting will include the initial review, discussion, and evaluation of ''Strengthening National Capacity in Malaria and Other Infectious Disease Operations Research, Funding Opportunity Announcement (FOA) CK09–004.'' This meeting was initially held June 1, 2009. A reviewer was unable to participate unexpectedly and the meeting was held in the absence of the required quorum; therefore, the panel will be reconvened to review the application received in response to the announcement.

FOR FURTHER INFORMATION CONTACT: Wendy Carr, PhD, CDC, 1600 Clifton Road, NE., Mailstop D60, Atlanta, GA 30333, Telephone: (404) 498–2276.

The Director, Management Analysis and Services Office, has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities, for both CDC and the Agency for Toxic Substances and Disease Registry.

Dated: July 7, 2009.

Elaine L. Baker,

Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. E9–16461 Filed 7–10–09; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2009–N–0284]

Food and Drug Administration Regulation and Licensure of Whole Blood and Blood Components, Including Source Plasma; Public Workshop; Request for Comments

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice of public workshop; request for comments.

The Food and Drug Administration (FDA) is announcing a public workshop entitled ''FDA Regulation and Licensure of Whole Blood and Blood Components, Including Source Plasma.'' The purpose of the workshop is to educate industry on the licensure requirements and license application procedures for Whole Blood and blood components, including Source Plasma, and request comments on this topic.

Dates and Time: The public workshop will be held on September 15, 2009, from 8 a.m. to 5:30 p.m. and September 16, 2009, from 8 a.m. to 4 p.m.

Location: The public workshop will be held at The Universities at Shady Grove Conference Center, 9630 Gudelsky Dr., Bldg. 1, Rockville, MD 20850.

Contact Person: Rhonda Dawson, Center for Biologics Evaluation and Research (HFM–302), Food and Drug Administration, 1401 Rockville Pike, suite 400N, Rockville, MD 20852–1448, 301–827–6129, FAX: 301–827–2843, e-mail: *rhonda.dawson@fda.hhs.gov*.

Registration: Mail, fax, or e-mail your registration information (including name, title, firm name, address, telephone, and fax numbers) to the contact person (see *Contact Person*) by August 17, 2009. There is no registration fee for the public workshop. Early registration is recommended because seating is limited. Registration on the day of the public workshop will be provided on a space available basis beginning at 7:30 a.m.

If you need special accommodations due to a disability, please contact Rhonda Dawson (see *Contact Person*) at least 7 days in advance of the workshop.

Comments: All individuals wishing to submit questions to be addressed at the public workshop should submit written or electronic comments by August 17, 2009, to the Division of Dockets Management (HFA–305), Food and Drug Administration, 5630 Fishers Lane, rm 1061, Rockville, MD 20852. Submit electronic comments to *http://www.regulations.gov*. Submit a single copy of electronic comments or two paper copies of any mailed comments, except that individuals may submit one paper copy. Comments are to be identified with the docket number found in brackets in the heading of this document. Received comments may be seen in the Division of Dockets Management between 9 a.m. and 4 p.m., Monday through Friday.

SUPPLEMENTARY INFORMATION: FDA held a licensing workshop for blood establishments in 1995 to advise the blood and plasma industry on how to apply for a U.S. license to distribute Whole Blood and blood components, including Source Plasma, in interstate commerce. This workshop will build upon the 1995 workshop and provide regulatory updates since the last workshop. The workshop will include presentations by FDA on the following topics: (1) Requirements for licensure and applicable regulations and guidance documents for Whole Blood and blood components, including Source Plasma; (2) managed review process; (3) review criteria for various submissions; (4) blood establishment registration and product listing requirements; (5) inspections of blood establishments pending licensure and approval; and (6) requests for exceptions or use of alternative procedures to the regulations. The workshop will include a question and answer session with workshop participants.

Transcripts: Transcripts of the public workshop may be requested in writing from the Freedom of Information Office (HFI–35), Food and Drug Administration, 5600 Fishers Lane, rm. 6–30, Rockville, MD 20857, approximately 15 working days after the public workshop at a cost of 10 cents per page. A transcript of the public workshop will be available on the Internet at *http://www.fda.gov/cber/minutes/workshop-min.htm*.

Dated: July 7, 2009.

Jeffrey Shuren,

Associate Commissioner for Policy and Planning.

[FR Doc. E9–16657 Filed 7–10–09; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Advisory Committee on Immunization Practices (ACIP)

In accordance with Section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), the Centers for Disease Control and Prevention (CDC), announces the following meeting of the aforementioned committee:

Time and Date: 8 a.m.–4 p.m., July 29, 2009.

Place: CDC, Tom Harkin Global Communications Center, 1600 Clifton Road, NE., Building 19, Kent ''Oz'' Nelson Auditorium, Atlanta, Georgia 30333.

Status: Open to the public, limited only by the space available.

Purpose: The committee is charged with advising the Director, CDC, on the appropriate uses of immunizing agents. In addition, under 42 U.S.C. Section 1396s, the committee is mandated to establish and periodically review and, as appropriate, revise the list of vaccines for administration to vaccine-eligible children through the Vaccines for Children program, along with schedules regarding the appropriate periodicity, dosage, and contraindications applicable to the vaccines.

Matters To Be Discussed: The agenda will include discussions related to recommendations for use of influenza vaccines in the prevention and control of novel (pandemic) influenza A (H1N1); novel H1N1 epidemiology in the United States; novel H1N epidemiology, international settings; modeling novel H1N1 influenza impact and impact of vaccination; implementation planning; vaccine development and formulation; and the Food and Drug Administration/Vaccines and Related Biological Products Advisory Committee update. Agenda items are subject to change as priorities dictate.

Contact Person for More Information: Antonette Hill, Immunization Services Division, National Center for Immunization and Respiratory Diseases, CDC, 1600 Clifton Road, NE., Mailstop E–05, Atlanta, Georgia 30333, Telephone: (404) 639–8836, Fax: (404) 639–8905.

The Director, Management Analysis and Services Office, has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities for both the CDC and Agency for Toxic Substances and Disease Registry.

Dated: July 6, 2009.

Elaine L. Baker,

Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

[FR Doc. E9–16475 Filed 7–10–09; 8:45 am]

BILLING CODE 4160–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2009–N–0664]

Orthopaedic and Rehabilitation Devices Panel of the Medical Devices Advisory Committee; Notice of Meeting

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

This notice announces a forthcoming meeting of a public advisory committee of the Food and Drug Administration (FDA). The meeting will be open to the public.

Name of Committee: Orthopaedic and Rehabilitation Devices Panel of the Medical Devices Advisory Committee.

General Function of the Committee: To provide advice and recommendations to the agency on FDA's regulatory issues.

Date and Time: The meeting will be held on August 18 and 19, 2009, from 8 a.m. to 5 p.m.

Location: Hilton Washington DC North/Gaithersburg, Salons A, B and C, 620 Perry Pkwy., Gaithersburg, MD.

Contact Person: Ronald P. Jean, Center for Devices and Radiological Health (HFZ–410), Food and Drug Administration, 9200 Corporate Blvd., Rockville, MD, 20850, 240–276–3676, or FDA Advisory Committee Information Line, 1–800–741–8138 (301–443–0572 in the Washington, DC area), code 3014512521. Please call the Information Line for up-to-date information on this meeting. A notice in the **Federal Register** about last minute modifications that impact a previously announced advisory committee meeting cannot always be published quickly enough to provide timely notice. Therefore, you should always check the agency's Web site and call the appropriate advisory committee hot line/phone line to learn about possible modifications before coming to the meeting.

Agenda: On August 18, 2009, the committee will discuss, make recommendations and vote on a premarket approval application (PMA) for the CoMplete Acetabular Hip System, sponsored by DePuy Orthopaedics. This device system is intended for use as a primary joint replacement prosthesis in total hip arthroplasty, and is indicated for skeletally mature patients suffering severe pain and disability due to structural damage in the hip joint from non-inflammatory degenerative joint disease and its composite diagnoses of osteoarthritis or post-traumatic arthritis. On August 19, 2009, the committee will discuss, make recommendations and vote on a PMA for Durolane, sponsored by Q–Med AB. This device is indicated for the treatment of pain caused by osteoarthritis of the knee in patients who have failed to respond adequately to conservative non-pharmacological therapy and simple analgesics, e.g., acetaminophen.

FDA intends to make background material available to the public no later than 2 business days before the meeting. If FDA is unable to post the background material on its Web site prior to the meeting, the background material will be made publicly available at the location of the advisory committee meeting, and the background material will be posted on FDA's Web site after the meeting. Background material is available at *http://www.fda.gov/AdvisoryCommittees/Calendar/default.htm*, click on the year 2009 and scroll down to the appropriate advisory committee link.

Procedure: Interested persons may present data, information, or views, orally or in writing, on issues pending before the committee. Written submissions may be made to the contact person on or before August 4, 2009. Oral presentations from the public will be scheduled at approximately 1 p.m., immediately following lunch on both days. Those desiring to make formal oral presentations should notify the contact person and submit a brief statement of the general nature of the evidence or arguments they wish to present, the names and addresses of proposed participants, and an indication of the approximate time requested to make their presentation on or before July 27, 2009. Time allotted for each presentation may be limited. If the number of registrants requesting to speak is greater than can be reasonably accommodated during the scheduled open public hearing session, FDA may conduct a lottery to determine the speakers for the scheduled open public hearing session. The contact person will notify interested persons regarding their request to speak by July 28, 2009.

Persons attending FDA's advisory committee meetings are advised that the agency is not responsible for providing access to electrical outlets.

FDA welcomes the attendance of the public at its advisory committee meetings and will make every effort to accommodate persons with physical disabilities or special needs. If you require special accommodations due to a disability, please contact Ann Marie Williams, Conference Management Staff, 301–796–5966, at least 7 days in advance of the meeting.

FDA is committed to the orderly conduct of its advisory committee meetings. Please visit our Web site at *http://www.fda.gov/AdvisoryCommittee/AboutAdvisoryCommittee/ucm111462.htm* for procedures on public conduct during advisory committee meetings.

Notice of this meeting is given under the Federal Advisory Committee Act (5 U.S.C. app. 2).

Dated: July 1, 2009.

Randall W. Lutter,

Deputy Commissioner for Policy.

[FR Doc. E9–16409 Filed 7–10–09; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Environmental Health Sciences; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. App.), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute of Environmental Health Sciences Special Emphasis Panel; ARRA Stem Cell Competitive Supplement Review.

Date: July 27, 2009.

Time: 2 p.m. to 4 p.m.

Agenda: To review and evaluate grant applications.

Place: Nat. Inst. of Environmental Health Sciences, Building 101, Rodbell Auditorium, 111 T. W. Alexander Drive, Research Triangle Park, NC 27709 (Telephone Conference Call).

Contact Person: Sally Eckert-Tilotta, PhD, Scientific Review Administrator, Nat. Institute of Environmental Health Sciences, Office of Program Operations, Scientific Review Branch, P.O. Box 12233, Research Triangle Park, NC 27709. (919) 541–1446. *Eckertt1@niehs.nih.gov*.

(Catalogue of Federal Domestic Assistance Program Nos. 93.115, Biometry and Risk Estimation—Health Risks from Environmental Exposures; 93.142, NIEHS Hazardous Waste Worker Health and Safety Training; 93.143, NIEHS Superfund

Hazardous Substances—Basic Research and Education; 93.894, Resources and Manpower Development in the Environmental Health Sciences; 93.113, Biological Response to Environmental Health Hazards; 93.114, Applied Toxicological Research and Testing; 93.701, ARRA Related Biomedical Research and Research Support Awards., National Institutes of Health, HHS)

Dated: July 7, 2009.

Jennifer Spaeth,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. E9–16565 Filed 7–10–09; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HOMELAND SECURITY

U.S. Citizenship and Immigration Services

Agency Information Collection Activities: Form I–693, Revision of a Currently Approved Information Collection; Comment Request

ACTION: 30–Day Notice of Information Collection Under Review: Form I–693, Report of Medical Examination and Vaccination Record, OMB Control No. 1615–0033.

The Department of Homeland Security, U.S. Citizenship and Immigration Services (USCIS) has submitted the following information collection request to the Office of Management and Budget (OMB) for review and clearance in accordance with the Paperwork Reduction Act of 1995. The information collection was previously published in the **Federal Register** on April 24, 2009, at 74 FR 18737, allowing for a 60-day public comment period. USCIS received one comment.

The purpose of this notice is to allow an additional 30 days for public comments. Comments are encouraged and will be accepted until August 12, 2009. This process is conducted in accordance with 5 CFR 1320.10.

Written comments and/or suggestions regarding the item(s) contained in this notice, especially regarding the estimated public burden and associated response time, should be directed to the Department of Homeland Security (DHS), and to the Office of Information and Regulatory Affairs, Office of Management and Budget (OMB), USCIS Desk Officer. Comments may be submitted to: USCIS, Chief, Regulatory Products Division, Clearance Office, 111 Massachusetts Avenue, Washington, DC 20529–2210. Comments may also be submitted to DHS via facsimile to 202–272–8352 or via e-mail at *rfs.regs@dhs.gov*, and to the OMB USCIS Desk Officer via facsimile at 202–395–5806 or via e-mail at *oira_submission@omb.eop.gov*.

When submitting comments by e-mail, please make sure to add OMB Control No. 1615–0033 in the subject box. Written comments and suggestions from the public and affected agencies should address one or more of the following four points:

(1) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

(2) Evaluate the accuracy of the agencies estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

(3) Enhance the quality, utility, and clarity of the information to be collected; and

(4) Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses.

Overview of this information collection:

(1) *Type of Information Collection:* Revision of a currently approved information collection.

(2) *Title of the Form/Collection:* Report of Medical Examination and Vaccination Record.

(3) *Agency form number, if any, and the applicable component of the Department of Homeland Security sponsoring the collection:* Form I–693. U.S. Citizenship and Immigration Services.

(4) *Affected public who will be asked or required to respond, as well as brief abstract:* Primary: *Individuals or households.* The information on the application will be used by USCIS in considering the eligibility for adjustment of status under 8 CFR part 209 and 8 CFR 210.5, 245.1, and 245a.3.

(5) *An estimate of the total number of respondents and the amount of time estimated for an average respondent to respond:* 800,000 responses at 2.5 hours per response.

(6) *An estimate of the total public burden (in hours) associated with the collection:* 2,000,000 annual burden hours.

If you need a copy of the information collection instrument, please visit the Web site at: *http://www.regulations.gov/*.

We may also be contacted at: USCIS, Regulatory Products Division, 111 Massachusetts Avenue, NW., Washington, DC 20529–2210, Telephone number 202–272–8377.

Dated: July 8, 2009.

Stephen Tarragon,

Deputy Chief, Regulatory Products Division, U.S. Citizenship and Immigration Services.

[FR Doc. E9–16541 Filed 7–10–09; 8:45 am]

BILLING CODE 9111–97–P

DEPARTMENT OF HOMELAND SECURITY

U.S. Citizenship and Immigration Services

Agency Information Collection Activities: Form I–730; Extension of an Existing Information Collection; Comment Request

ACTION: 60-Day Notice of Information Collection Under Review; Form I–730, Refugee/Asylee Relative Petition; OMB Control No. 1615–0037.

The Department Homeland Security, U.S. Citizenship and Immigration Services (USCIS) has submitted the following information collection request for review and clearance in accordance with the Paperwork Reduction Act of 1995. The information collection is published to obtain comments from the public and affected agencies. Comments are encouraged and will be accepted for sixty days until September 11, 2009.

During this 60 day period, USCIS will be evaluating whether to revise the Form I–730. Should USCIS decide to revise Form I–730 we will advise the public when we publish the 30-day notice in the **Federal Register** in accordance with the Paperwork Reduction Act. The public will then have 30 days to comment on any revisions to the Form I–730.

Written comments and/or suggestions regarding the item(s) contained in this notice, especially regarding the estimated public burden and associated response time, should be directed to the Department of Homeland Security (DHS), USCIS, Chief, Regulatory Products Division, Clearance Officer, 111 Massachusetts Avenue, NW., Washington, DC 20529–2210. Comments may also be submitted to DHS via facsimile to 202–272–8352 or via e-mail at *rfs.regs@dhs.gov*. When submitting comments by e-mail, please make sure to add OMB Control No. 1615–0037 in the subject box. Written comments and suggestions from the public and affected agencies concerning the collection of information should

address one or more of the following four points:

(1) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

(2) Evaluate the accuracy of the agencies estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

(3) Enhance the quality, utility, and clarity of the information to be collected; and

(4) Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.*, permitting electronic submission of responses.

Overview of This Information Collection

(1) *Type of Information Collection:* Extension of an existing information collection.

(2) *Title of the Form/Collection:* Refugee/Asylee Relative Petition.

(3) *Agency form number, if any, and the applicable component of the Department of Homeland Security sponsoring the collection:* Form I–730; U.S. Citizenship and Immigration Services (USCIS).

(4) *Affected public who will be asked or required to respond, as well as a brief abstract: Primary:* Individuals or households. This form will be used by an asylee or refugee to file on behalf of his of her spouse and/or children provided that the relationship to the refugee/asylee existed prior to their admission to the United States. The information collected on this form will be used by USCIS to determine eligibility for the requested immigrant benefit.

(5) *An estimate of the total number of respondents and the amount of time estimated for an average respondent to respond:* 86,400 responses at 35 minutes (.583) per response.

(6) *An estimate of the total public burden (in hours) associated with the collection:* 50,371 annual burden hours.

If you need a copy of the information collection instrument, please visit the Web site at: *http://www.regulations.gov/.*

We may also be contacted at: USCIS, Regulatory Products Division, 111 Massachusetts Avenue, NW., Washington, DC 20529–2210, Telephone number 202–272–8377.

Dated: July 9, 2009.

Stephen Tarragon,

Deputy Chief, Regulatory Products Division, U.S. Citizenship and Immigration Services, Department of Homeland Security.

[FR Doc. E9–16680 Filed 7–10–09; 8:45 am]

BILLING CODE 9111–97–P

DEPARTMENT OF HOMELAND SECURITY

U.S. Citizenship and Immigration Services

Agency Information Collection Activities: Form I–602; Extension of an Existing Information Collection; Comment Request

ACTION: 60-Day Notice of Information Collection Under Review; Form I–602, Application by Refugee for Waiver of Grounds of Excludability; OMB Control No. 1615–0069.

The Department Homeland Security, U.S. Citizenship and Immigration Services (USCIS) has submitted the following information collection request for review and clearance in accordance with the Paperwork Reduction Act of 1995. The information collection is published to obtain comments from the public and affected agencies. Comments are encouraged and will be accepted for sixty days until September 11, 2009.

During this 60 day period, USCIS will be evaluating whether to revise the Form I–602. Should USCIS decide to revise Form I–602 we will advise the public when we publish the 30-day notice in the **Federal Register** in accordance with the Paperwork Reduction Act. The public will then have 30 days to comment on any revisions to the Form I–602.

Written comments and/or suggestions regarding the item(s) contained in this notice, especially regarding the estimated public burden and associated response time, should be directed to the Department of Homeland Security (DHS), USCIS, Chief, Regulatory Products Division, Clearance Officer, 111 Massachusetts Avenue, NW., Washington, DC 20529–2210. Comments may also be submitted to DHS via facsimile to 202–272–8352 or via e-mail at *rfs.regs@dhs.gov*. When submitting comments by e-mail, please make sure to add OMB Control No. 1615–0069 in the subject box. Written comments and suggestions from the public and affected agencies concerning the collection of information should address one or more of the following four points:

(1) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

(2) Evaluate the accuracy of the agencies estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

(3) Enhance the quality, utility, and clarity of the information to be collected; and

(4) Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.*, permitting electronic submission of responses.

Overview of this Information Collection

(1) *Type of Information Collection:* Extension of an existing information collection.

(2) *Title of the Form/Collection:* Application by Refugee for Waiver of Grounds of Excludability.

(3) *Agency form number, if any, and the applicable component of the Department of Homeland Security sponsoring the collection:* Form I–602; U.S. Citizenship and Immigration Services (USCIS).

(4) *Affected public who will be asked or required to respond, as well as a brief abstract: Primary:* Individuals or households. Form I–602 is necessary to establish eligibility for waiver of excludability based on humanitarian, family unity, or public interest.

(5) *An estimate of the total number of respondents and the amount of time estimated for an average respondent to respond:* 2,500 responses at 15 minutes (.25) per response.

(6) *An estimate of the total public burden (in hours) associated with the collection:* 625 annual burden hours.

If you need a copy of the information collection instrument, please visit the Web site at: *http://www.regulations.gov/.*

We may also be contacted at: USCIS, Regulatory Products Division, 111 Massachusetts Avenue, NW., Washington, DC 20529–2210, Telephone number 202–272–8377.

Dated: July 9, 2009.

Stephen Tarragon,

Deputy Chief, Regulatory Products Division, U.S. Citizenship and Immigration Services, Department of Homeland Security.

[FR Doc. E9–16679 Filed 7–10–09; 8:45 am]

BILLING CODE 9111–97–P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

[Internal Agency Docket No. FEMA–1849–DR; Docket ID FEMA–2008–0018]

Kansas; Major Disaster and Related Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Notice.

SUMMARY: This is a notice of the Presidential declaration of a major disaster for the State of Kansas (FEMA–1849–DR), dated June 25, 2009, and related determinations.

DATES: *Effective Date:* June 25, 2009.

FOR FURTHER INFORMATION CONTACT: Peggy Miller, Disaster Assistance Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472, (202) 646–3886.

SUPPLEMENTARY INFORMATION: Notice is hereby given that, in a letter dated June 25, 2009, the President issued a major disaster declaration under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (the ''Stafford Act''), as follows:

I have determined that the damage in certain areas of the State of Kansas resulting from severe storms, flooding, straight-line winds, and tornadoes during the period of April 25 to May 16, 2009, is of sufficient severity and magnitude to warrant a major disaster declaration under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121 *et seq.* (the ''Stafford Act''). Therefore, I declare that such a major disaster exists in the State of Kansas.

In order to provide Federal assistance, you are hereby authorized to allocate from funds available for these purposes such amounts as you find necessary for Federal disaster assistance and administrative expenses.

You are authorized to provide Public Assistance in the designated areas, Hazard Mitigation throughout the State, and any other forms of assistance under the Stafford Act that you deem appropriate. Consistent with the requirement that Federal assistance is supplemental, any Federal funds provided under the Stafford Act for Public Assistance and Hazard Mitigation will be limited to 75 percent of the total eligible costs. If Other Needs Assistance under Section 408 of the Stafford Act is later requested and warranted, Federal funding under that program will also be limited to 75 percent of the total eligible costs.

Further, you are authorized to make changes to this declaration to the extent allowable under the Stafford Act.

The Federal Emergency Management Agency (FEMA) hereby gives notice that pursuant to the authority vested in the Administrator, under Executive Order 12148, as amended, Michael L. Karl, of FEMA is appointed to act as the Federal Coordinating Officer for this major disaster.

The following areas of the State of Kansas have been designated as adversely affected by this major disaster:

Anderson, Barber, Bourbon, Butler, Chase, Cherokee, Coffey, Cowley, Crawford, Elk, Finney, Greenwood, Harper, Harvey, Kingman, Labette, Linn, Lyon, Marion, Marshall, Montgomery, Morris, Neosho, Reno, Rice, Sumner, Wabaunsee, and Wilson Counties for Public Assistance.

All counties within the State of Kansas are eligible to apply for assistance under the Hazard Mitigation Grant Program.

The following Catalog of Federal Domestic Assistance Numbers (CFDA) are to be used for reporting and drawing funds: 97.030, Community Disaster Loans; 97.031, Cora Brown Fund; 97.032, Crisis Counseling; 97.033, Disaster Legal Services; 97.034, Disaster Unemployment Assistance (DUA); 97.046, Fire Management Assistance Grant; 97.048, Disaster Housing Assistance to Individuals and Households In Presidentially Declared Disaster Areas; 97.049, Presidentially Declared Disaster Assistance—Disaster Housing Operations for Individuals and Households; 97.050, Presidentially Declared Disaster Assistance to Individuals and Households—Other Needs; 97.036, Disaster Grants—Public Assistance (Presidentially Declared Disasters); 97.039, Hazard Mitigation Grant.

W. Craig Fugate,

Administrator, Federal Emergency Management Agency.

[FR Doc. E9–16526 Filed 7–10–09; 8:45 am]

BILLING CODE 9111–23–P

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–5287–N–02]

Notice of Proposed Information Collection for Public Comment on the Participation Agreement, Baseline Survey, Tracking Survey and Key Informant Interview Guide for the Homeless Family Interventions Study

AGENCY: Office of Policy Development and Research, HUD.

ACTION: Notice.

SUMMARY: The proposed information collection requirement described below will be submitted to the Office of Management and Budget (OMB) for review, as required by the Paperwork Reduction Act of 1995, Public Law 104–13 (44 U.S.C. 3506(c)(2)(A)). The Department is soliciting public comments on the subject proposal.

DATES: *Comments Due Date: September 11, 2009.*

ADDRESSES: Interested persons are invited to submit comments regarding this proposal. Comments should refer to the proposal by name and/or OMB Control Number and should be sent to: Reports Liaison Officer, Office of Policy Development and Research, Department of Housing and Urban Development, 451 7th Street, SW., Room 8234, Washington, DC 20410.

FOR FURTHER INFORMATION CONTACT: Paul B. Dornan at (202) 402–4486 (this is not a toll-free number). Copies of the proposed forms and other available documents submitted to OMB may be obtained from Mr. Dornan.

SUPPLEMENTARY INFORMATION: The Department will submit the proposed information collection to OMB for review, as required by the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35, as amended).

This Notice is soliciting comments from members of the public and affected agencies concerning the proposed collection of information to: (1) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; (2) Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information; (3) Enhance the quality, utility, and clarity of the information to be collected; and (4) Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated collection techniques or other forms of information technology that will reduce the burden (e.g., permitting electronic submission of responses).

This Notice also lists the following information:

Title of Proposal: Homeless Families Interventions Study.

OMB Control Number: 2528-pending.

Description of the need for the information and proposed use: The Participation Agreement, the Baseline and Tracking Survey Instruments and the Key Informant Interview Guide are all of the instruments necessary to put the Homeless Family Interventions Study into place. The Homeless Families Interventions Study is the first randomized experiment designed to test the impact of various combinations of housing and supportive services on the subsequent housing stability and well-being of homeless families. The Senate Appropriations Committee directed the Department in FY 2006 to ''undertake research to ascertain the impact of various service and housing interventions in ending homelessness

for families.'' These instruments establish the research foundation on which the Department can meet that direction. They will permit the research team a set of baseline characteristics and conditions for both an experimental and a control group with which later characteristics and conditions for those same participants can be compared. A subsequent **Federal Register** Notice will include the follow-on survey which will permit the Department to report on the effects of various housing and services interventions on homeless families over time.

Members of affected public: Households.

Estimation of the total number of hours needed to prepare the information collection including number of respondents, frequency of response, and hours of response:

ESTIMATED RESPONDENT BURDEN HOURS AND COSTS

Form	Respondent sample	Number of respondents	Average time to complete (minimum, maximum) in minutes	Frequency	Total burden (hours)
Baseline Survey	All enrolled families (N=3,000).	3,000	40 (35, 50)	1	2,000
Tracking Interview	All enrolled families (N=3,000).	3,000	10 (8, 15)	2	1,000
Tracking Letters	All enrolled families (N=3,000).	3,000	5 (3, 10)	3	750
Key Informant Interviews	Staff from programs providing services in the studied interventions.	300 (up to 25 respondents in each site).	60	3 responses per respondent to collect all needed program information.	900
Total Burden Hours					4,650

Respondent's Obligation: Voluntary.

Status of the proposed information collection: Pending OMB approval.

Authority: Title 13 U.S.C. Section 9(a), and Title 12, U.S.C., Section 1701z–1 *et seq.*

Dated: July 2, 2009.

Jean Lin Pao,

General Deputy Assistant Secretary for Policy Development and Research.

[FR Doc. E9–16547 Filed 7–10–09; 8:45 am]

BILLING CODE 4210–67–P

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–5338–N–01]

Affirmatively Furthering Fair Housing and Fair Housing Plans; Notice of Informal Meeting

AGENCY: Office of the Assistant Secretary for Fair Housing and Equal Opportunity, HUD.

ACTION: Notice.

SUMMARY: This notice advises the public of an informal meeting that HUD intends to hold for the purpose of obtaining individual views and gathering information on specific issues related to HUD's intended development of a proposed rule concerning the obligation to affirmatively further fair housing. The issues for which HUD seeks input are primarily directed to improving HUD's oversight of recipients' implementation of the duty to affirmatively further fair housing. HUD specifically invites to this meeting representatives of fair housing and civil rights organizations, State and local governments, public housing agencies, private and public housing providers, lending institutions, and other interested members of the public.

Date and Location of Meeting: The meeting will be held on Wednesday, July 22, 2009, from 2 p.m. to 4 p.m. EDT, at HUD Headquarters, in Suite A of the Brooke-Mondale Auditorium, first floor of the Robert Weaver Building (HUD Headquarters), 451 7th Street, SW., Washington, DC 20410.

FOR FURTHER INFORMATION CONTACT: Bryan Greene, General Deputy Assistant Secretary for Fair Housing and Equal Opportunity, Room 5100, Department of Housing and Urban Development, 451 7th Street, SW., Washington, DC 20410; telephone number 202–708–4252 (this is not a toll-free number). Persons with hearing or speech impairments may access this telephone number via TTY by calling the toll-free Federal Information Relay Service at 800–877–8339.

SUPPLEMENTARY INFORMATION: A central part of HUD's mission is to ensure nondiscrimination in its programs and to promote fair and equal opportunities for all individuals. HUD and its program recipients have the statutory responsibility to affirmatively further fair housing opportunities in HUD programs.

If you are interested in participating in the July 22, 2009, meeting, please send an e-mail to: *affh@hud.gov*. The following information should be included in the e-mail: (a) Your full name; (b) name of your organization; (c) telephone number; (d) e-mail address; and (e) make, model, and serial number of laptop, if you plan on bringing a laptop computer to the meeting.

The purpose of this meeting is to obtain views, opinions, perspectives, and suggestions from meeting participants, rather than try and reach consensus on affirmatively furthering fair housing. Specific issues that HUD will ask meeting participants to address include the following:

- How can the existing process be improved;
- What documentation recipients currently use to demonstrate compliance with affirmatively furthering fair housing requirements and to support their certifications to affirmatively further fair housing;
- What factors should be included in an analysis of impediments for fair housing choice (AI);
- How often should the AIs be updated, while not creating undue burden;
- What are the advantages and disadvantages of creating a regional approach to affirmatively further fair housing; and
- What can communities and public housing agencies do to reduce housing segregation and increase housing

opportunities for protected classes under the Federal housing civil rights laws.

The views, suggestions, and information provided at the July 22, 2009, informal meeting will inform HUD as it considers changes to improve HUD's guidance to grantees and enhance HUD's regulatory oversight.

Dated: July 6, 2009.

John Trasviña,

Assistant Secretary for Fair Housing and Equal Opportunity.

[FR Doc. E9–16542 Filed 7–8–09; 4:15 pm]

BILLING CODE 4210–67–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[AA–11153–31; AK–965–1410–KC–P]

Alaska Native Claims Selection

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of decision approving lands for conveyance.

SUMMARY: As required by 43 CFR 2650.7(d), notice is hereby given that an appealable decision approving the reserved mineral estate in certain lands for conveyance pursuant to the Alaska Native Claims Settlement Act and Sec. 12(b)(3) of the Act of January 2, 1976, will be issued to Cook Inlet Region, Inc. The lands are in the vicinity of Hicks and Pinochle Creeks, Alaska, and are located in:

Seward Meridian, Alaska

T. 20 N., R. 9 E.,
Secs. 16, 19, and 20;
Secs. 21, 22, and 23;
Secs. 25 to 30, inclusive;
Sec. 35.

Containing 2,995.91 acres.

Notice of the decision will also be published four times in the Anchorage Daily News.

DATES: The time limits for filing an appeal are:

1. Any party claiming a property interest which is adversely affected by the decision shall have until August 12, 2009 to file an appeal.

2. Parties receiving service of the decision by certified mail shall have 30 days from the date of receipt to file an appeal.

Parties who do not file an appeal in accordance with the requirements of 43 CFR part 4, subpart E, shall be deemed to have waived their rights.

ADDRESSES: A copy of the decision may be obtained from: Bureau of Land Management, Alaska State Office, 222 West Seventh Avenue, #13, Anchorage, Alaska 99513–7504.

FOR FURTHER INFORMATION CONTACT: The Bureau of Land Management by phone at 907–271–5960, or by e-mail at *ak.blm.conveyance@ak.blm.gov.* Persons who use a telecommunication device (TTD) may call the Federal Information Relay Service (FIRS) at 1–800–877–8330, 24 hours a day, seven days a week, to contact the Bureau of Land Management.

Christy Favorite,

Land Law Examiner, Land Transfer Adjudication II Branch.

[FR Doc. E9–16413 Filed 7–10–09; 8:45 am]

BILLING CODE 4310–JA–P

DEPARTMENT OF THE INTERIOR

Geological Survey

Call for Nominations to the National Geospatial Advisory Committee

AGENCY: U.S. Geological Survey, Interior.

ACTION: Call for Nominations, National Geospatial Advisory Committee.

SUMMARY: The Department of the Interior is seeking nominations to serve on the National Geospatial Advisory Committee (NGAC). The NGAC is a Federal Advisory Committee established under the authority of the Federal Advisory Committee Act (FACA). The Committee provides advice and recommendations to the Federal Geographic Data Committee (FGDC), through the FGDC Chair (the Secretary of the Interior or designee), related to management of Federal geospatial programs, the development of the National Spatial Data Infrastructure (NSDI), and the implementation of Office of Management and Budget (OMB) Circular A–16 and Executive Order 12906. The Committee reviews and comments upon geospatial policy and management issues and provides a forum to convey views representative of non-Federal stakeholders in the geospatial community.

DATES: Nominations to participate on this Committee must be received by August 21, 2009.

ADDRESSES: Send nominations electronically to *ngacnominations@fgdc.gov*, or by mail to John Mahoney, U.S. Geological Survey, U.S. Department of the Interior, 909 First Avenue, Suite 800, Seattle, WA 98104.

Nominations should include:

1. Contact information for the nominee (name, title, organization, mailing address, e-mail address, phone number).

2. A statement summarizing the nominee's qualifications and interest in Committee membership and describing the nominee's ability to represent a stakeholder group.

3. A biographical sketch, resume, or vita.

4. One letter of reference and a list of two additional references with contact information.

Additional information and instructions about the nomination process are posted on the NGAC Web page at *http://www.fgdc.gov/ngac.*

FOR FURTHER INFORMATION CONTACT: John Mahoney, USGS (206–220–4621).

SUPPLEMENTARY INFORMATION: The Committee conducts its operations in accordance with the provisions of the FACA. It reports to the Secretary of the Interior through the Chair of the FGDC Steering Committee and functions solely as an advisory body. The Committee provides recommendations and advice to the Department and the FGDC on policy and management issues related to the effective operation of Federal geospatial programs.

The NGAC includes 25–30 members, selected to generally achieve a balanced representation of the viewpoints of the various partners involved in national geospatial activities. NGAC members are appointed for staggered terms, and approximately one-half of the seats on the committee will be appointed during this round of appointments.

Nominations will be reviewed by the FGDC. Additional information may be requested from nominees. Final selection and appointment of committee members will be made by the Secretary of the Interior.

The Committee meets approximately 3–4 times per year. Committee members will serve without compensation. Travel and per diem costs will be provided for Committee members by USGS. The USGS will provide necessary support services to the Committee. Committee meetings will be open to the public. Notice of committee meetings will be published in the **Federal Register** at least 15 days before the date of the meeting. The public will have an opportunity to provide input at these meetings.

In accordance with FACA, a copy of the Committee's charter will be filed with the Committee Management Secretariat, General Services Administration. The current version of the NGAC charter is available at *http://www.fgdc.gov/ngac.*

Dated: July 5, 2009.

Ivan DeLoatch,

Staff Director, Federal Geographic Data Committee.

[FR Doc. E9–16386 Filed 7–10–09; 8:45 am]

BILLING CODE 4311–AM–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[LLNVS03000.L51010000.ER0000.F09F8590; NVN–84359; 9–08807: TAS:14X5017]

Notice of Intent to Prepare an Environmental Impact Statement for the Proposed Solar Millennium, LLC, Amargosa Farm Road Solar Energy Project, Nye County, NV

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of Intent.

SUMMARY: The Bureau of Land Management (BLM) Field Office, Southern Nevada District, Pahrump Field Office intends to prepare an environmental impact statement (EIS) for the Amargosa Farm Road Solar Energy Project, located on public lands in Nye County, Nevada and by this notice is announcing the beginning of the scoping process and soliciting input on the identification of issues.

DATES: This notice initiates public scoping. Scoping comments shall be submitted on or before August 12, 2009.

The BLM will announce public scoping meetings to identify relevant issues through local news media, newsletters, and the BLM Web site (*http://www.blm.gov/nv/st/en/fo/lvfo.html*) at least 15 days prior to each meeting. We will provide additional opportunities for public participation upon publication of the Draft RMP/EIS, including a 90-day public comment period.

ADDRESSES: Comments related to the project may be submitted by any of the following methods:

- *E-mail: solar_millennium@blm.gov.*
- *Fax:* (702) 515–5064 (attention: Gregory Helseth).
- *Mail:* Bureau of Land Management, Southern Nevada District Office, Pahrump Field Office, *Attn:* Gregory Helseth, Project Manager, 4701 North Torrey Pines Drive, Las Vegas, NV 89130–2301.

Documents pertinent to this project may be examined at the Pahrump Field Office. Additional opportunities for public participation will be provided on publication of the draft EIS.

FOR FURTHER INFORMATION CONTACT: For further information and/or to have your name added to the mailing list, call Gregory Helseth, (702) 515–5173, or *e-mail: gregory_helseth@blm.gov.*

SUPPLEMENTARY INFORMATION: Solar Millennium, LLC, has submitted a right-of-way application to BLM to construct two concentrated solar thermal parabolic trough power plant facilities on public lands, approximately 80 miles northwest of Las Vegas, in Nye County, Nevada. The Project site would consist of approximately 4,350 acres of public land located in Amargosa Valley, south of Highway 95. Each facility is expected to operate for approximately 30 years. Each plant would utilize solar thermal parabolic trough technology, consisting of a 242 megawatt (MW) power block equipped with thermal storage tanks capable of producing additional energy for 3.5 hours after sundown, and a solar field composed of parabolic trough mirrors.

The solar field would be highly modular and would consist of ''loops,'' each containing 4 curved glass mirror collectors. A loop is 22m wide and 400m long (72.18′ wide and 1312.33′ long). The solar field would consist of approximately 400 loops. The orientation of the collectors would be north-south, and the collectors would track the sun from east to west during the day. The collector would focus the sun's direct beam radiation on a receiver tube. The row of collectors would have a hydraulic drive unit with sensors to track the sun's path throughout the day. The solar energy would heat a transfer fluid which cycles through a series of heat exchangers to generate steam, which drives a steam turbine to ultimately generate electricity. The electric output of the Project would be generated entirely by solar energy. No electricity would be generated by the use of fossil fuel in these facilities.

The proposed Project facilities would include the solar fields, power blocks, buildings, parking area, laydown area, stormwater retention pond, and evaporating ponds. A single overhead 230 kilovolt (kV) transmission line would connect the facilities to the nearby Valley Electric Valley substation, located on Anvil Road. Additional elements of the Project would include access roads and optional water pipeline. The proposed Project may require the rerouting of a road and an existing low voltage distribution power line. The EIS will analyze the site-specific impacts of the Project on air quality, biological resources, cultural resources, water resources, geological resources, paleontological resources, public health, socioeconomics, soils, traffic and transportation, and visual resources. It will analyze the geologic hazards, hazardous materials handling, land use and airspace, noise, waste management, worker safety, and fire protection potentially associated with the Project. It will also analyze facility design engineering, efficiency, and reliability; transmission system engineering; and transmission line safety and nuisance. Native American Tribal consultations will be conducted in accordance with policy, and Tribal concerns will be given due consideration. The EIS will include the consideration of any impacts on Indian trust assets.

Before including your address, phone number, e-mail address, or other personal identifying information in your comment, you should be aware that your entire comment, including your personal identifying information, may be made publicly available at any time. While you can ask us in your comment to withhold your personal identifying information from public review, we cannot guarantee that we will be able to do so. Federal, State, and local agencies, as well as individuals or organizations that may be interested in or affected by the BLM's decision on this project are invited to participate in the scoping process and, if eligible, may requested or be requested by the BLM to participate as a cooperating agency.

(Authority: 43 CFR Part 2800)

Patrick Putnam,

Field Manager, Pahrump Field Office.

[FR Doc. E9–16415 Filed 7–10–09; 8:45 am]

BILLING CODE 4310–HC–P

DEPARTMENT OF THE INTERIOR

Bureau of Reclamation

Mendota Pool Bypass and Reach 2B Improvements Project Under the San Joaquin River Restoration Program, Fresno and Madera Counties, CA

AGENCY: Bureau of Reclamation, Interior.

ACTION: Notice of intent to prepare an Environmental Impact Statement/Environmental Impact Report (EIS/EIR) and Notice of Scoping Meetings.

SUMMARY: The Bureau of Reclamation (Reclamation) and the California Department of Water Resources (DWR) are proposing to prepare a joint EIS/EIR, pursuant to the National Environmental Policy Act (NEPA) and the California Environmental Quality Act (CEQA), to evaluate effects of the proposed Mendota Pool Bypass and Reach 2B Channel Improvements Project (Proposed Action) under the San

Joaquin River Restoration Program (SJRRP or Program). The Proposed Action includes the construction, operation, and maintenance of the Mendota Pool Bypass and improvements, including the operation and maintenance of the San Joaquin River channel to allow Reach 2B to convey at least 4,500 cubic feet per second (cfs). The purpose of the proposed action is to improve Reach 2B conveyance conditions enough to provide a capacity of at least 4,500 cfs with integrated floodplain habitat, and to convey restoration flows of at least 4,500 cfs around Mendota Pool from Reach 2B downstream to Reach 3. The planning and environmental review for the Proposed Action is authorized under section 3406(c)(1) of the Central Valley Project Improvement Act (CVPIA) Title 34, (Pub. L. 102–575) and the San Joaquin River Restoration Act (SJRRA), included in Public Law 111–11. Construction of the Proposed Action is authorized under the SJRRA (Pub. L. 111–11). The Proposed Action is a component of the San Joaquin River Settlement.

Scoping meetings will be held to solicit input on alternatives, concerns, and issues to be addressed in the EIS/EIR. Written comments may also be sent.

DATES: Two scoping meetings will be held to solicit comments from interested parties to assist in determining the scope of the environmental analysis, including the alternatives to be addressed, and to identify the significant environmental issues related to the Proposed Action. The scoping meeting dates and locations are:

- Tuesday, July 28, 2009, 6 p.m.–8 p.m., Piccadilly Inn–Shaw, 2305 West Shaw Avenue, Fresno, California 93711; and
- Wednesday, July 29, 2009, 6 p.m.–8 p.m., Firebaugh City Council Chambers, 1659 13th Street, Firebaugh, California 96322.

Written comments on the scope of the EIS/EIR should be sent by August 17, 2009 to Ms. Margaret Gidding, Bureau of Reclamation, 2800 Cottage Way MP–170, Sacramento, CA 95825 or via e-mail at *MendotaPoolBypass@restoresjr.net.*

FOR FURTHER INFORMATION CONTACT: Ms. Margaret Gidding at the above address, by telephone at 916–978–5461, TDD 916–978–5608 or via fax at 916–978–5469. Additional information is available online at *http://www.restoresjr.net.* If special assistance is required at the scoping meetings, please contact Ms. Margaret Gidding at the above phone or fax numbers or via e-mail at *MendotaPoolBypass@restoresjr.net* no less than ten working days prior to the meetings.

SUPPLEMENTARY INFORMATION:

Reclamation and DWR are proposing to prepare a joint EIS/EIR, pursuant to NEPA and CEQA, to evaluate the proposed Mendota Pool Bypass and Reach 2B Channel Improvements Project (Proposed Action) under the SJRRP. The Proposed Action includes the construction, operation, and maintenance of the Mendota Pool Bypass and improvements, including the operation and maintenance of the San Joaquin River channel to allow Reach 2B to convey at least 4,500 cfs. The planning and environmental review for the Proposed Action is authorized under section 3406(c)(1) of the CVPIA and the SJRRA included in Public Law 111–11. Construction of the Proposed Action is authorized under the SJRRA (Pub. L. 111–11). The Proposed Action is a component of San Joaquin River Settlement.

The Proposed Action would include a bypass around the Mendota Pool to convey at least 4,500 cfs around the Mendota Pool and re-connect with the San Joaquin River downstream of Mendota Dam. The Proposed Action would also include constructing a bifurcation structure at the upper end of the bypass to convey at least 4,500 cfs into the Mendota Pool Bypass. The proposed Mendota Bypass Bifurcation Structure would be designed to divert water from the San Joaquin River to the Mendota Pool, consistent with the design channel capacity of Reach 2B which conveys flows to the Mendota Pool. The bifurcation structure would be designed to direct fish into the bypass channel and minimize or avoid fish passage into the Mendota Pool. Specific bypass alignments and facilities locations will be determined through the course of this site-specific study.

Reach 2B of the San Joaquin River extends from the Chowchilla Bypass Bifurcation Structure to the Mendota Dam. Proposed improvements to Reach 2B would include modifications to the San Joaquin River channel from the Chowchilla Bypass Bifurcation Structure to the new Mendota Bypass Bifurcation Structure to provide a capacity of at least 4,500 cfs with integrated floodplain habitat. The project would expand the Reach 2B channel capacity while accounting for new floodplain habitat. Specific channel modification actions would be determined through the course of this site-specific study. These actions would consider fisheries requirements, land uses, subsurface conditions, topography, and the condition of existing levees.

San Joaquin River Restoration Program

In 1988, a coalition of environmental groups led by the Natural Resources Defense Council (NRDC) filed a lawsuit challenging the renewal of the long-term water service contracts between the United States and the Central Valley Project Friant Division Contractors. After more than 18 years of litigation known as *NRDC, et al.* v. *Kirk Rodgers, et al.,* the NRDC, Friant Water Users Authority, and the Departments of the Interior and Commerce (Settling Parties) reached agreement on the terms and conditions of the San Joaquin River Settlement (Settlement) which was subsequently approved by the Court on October 23, 2006. The Settlement can be found online at *http://www.restoresjr.net.*

The Settlement Is Based on Two Parallel Goals

- The Restoration Goal—To restore and maintain fish populations in ''good condition'' in the main stem of the San Joaquin River below Friant Dam to the confluence of the Merced River, including naturally reproducing and self-sustaining populations of salmon and other fish; and
- The Water Management Goal—To reduce or avoid adverse water supply impacts to all of the Friant Division long-term Contractors that may result from the Interim Flows and Restoration Flows provided for in the Settlement.

The Settling Parties acknowledge that accomplishing the Goals requires planning, implementation, and funding of certain activities, such as environmental review, design, and construction. With regard to the Restoration Goal, the Settlement calls for a combination of channel and structural improvements along the San Joaquin River below Friant Dam, releases of additional water from Friant Dam to the confluence of the Merced River, and the reintroduction of spring and/or fall-run Chinook salmon.

The Settlement states that the Secretary of the Interior shall implement the terms and conditions of the Settlement. Additionally, the Settling Parties agreed that implementation of the Settlement shall also require participation of the State of California. Therefore, concurrent with the execution of the Settlement, the Settling Parties entered into a Memorandum of Understanding with the State of California, by and through the California Resources Agency, DWR, the Department of Fish and Game (DFG), and the California Environmental

Protection Agency (CalEPA), regarding the State's role in the implementation of the Settlement. The program established to implement the Settlement is the SJRRP, and the ''Implementing Agencies'' responsible for the management of the SJRRP include Reclamation, the U.S. Fish and Wildlife Service (USFWS), the National Marine Fisheries Service (NMFS), DWR, and DFG. The Federal Implementing agencies (Reclamation, USFWS and NMFS) are authorized to implement the Settlement under the SJRRA included in Public Law 111–11.

A Program Environmental Impact Statement/Environmental Impact Report (PEIS/EIR) is currently being developed for implementation of the SJRRP. If applicable, the EIS/EIR for the Proposed Action will supplement, tier from, incorporate by reference, or adopt relevant NEPA analyses from the PEIS/EIR. The Record of Decision for the PEIS/EIR is anticipated to be signed in 2010.

Public Disclosure

Before including your name, address, phone number, e-mail address, or other personal identifying information in your comment, you should be aware that your entire comment—including your personal identifying information—may be made publicly available at any time. While you can ask us in your comment to withhold your personal identifying information from public review, we cannot guarantee that we will be able to do so.

Dated: July 2, 2009.

Anastasia T. Leigh,

Acting Regional Environmental Officer, Mid-Pacific Region.

[FR Doc. E9–16462 Filed 7–10–09; 8:45 am]

BILLING CODE 4310–MN–P

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

[FWS–R9–IA–2009–N0103; 96300–1671–0000 FY09 R4]

Conference of the Parties to the Convention on International Trade in Endangered Species of Wild Fauna and Flora (CITES); Fifteenth Regular Meeting: Proposed Resolutions, Decisions, and Agenda Items Being Considered; Taxa Being Considered for Amendments to the CITES Appendices; Observer Information

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Notice.

SUMMARY: The United States, as a Party to the Convention on International Trade in Endangered Species of Wild Fauna and Flora (CITES), may submit proposed resolutions, decisions, and agenda items for consideration at meetings of the Conference of the Parties to CITES. The United States may also propose amendments to the CITES Appendices for consideration at meetings of the Conference of the Parties. The fifteenth regular meeting of the Conference of the Parties to CITES (CoP15) is tentatively scheduled to be held in Doha, Qatar, March 13–25, 2010.

With this notice, we describe proposed resolutions, decisions, and agenda items that the United States is considering submitting for consideration at CoP15; describe proposed amendments to the CITES Appendices (species proposals) that the United States is considering submitting for consideration at CoP15; invite your comments and information on these proposals; and provide information on how nongovernmental organizations based in the United States can attend CoP15 as observers.

DATES: We will consider written information and comments you submit concerning potential species proposals, and proposed resolutions, decisions, and agenda items that the United States is considering submitting for consideration at CoP15, and other items relating to CoP15, if we receive them by September 11, 2009.

ADDRESSES: Comments pertaining to proposed resolutions, decisions, and agenda items should be sent to the Division of Management Authority, U.S. Fish and Wildlife Service, 4401 North Fairfax Drive, Room 212, Arlington, VA 22203, or via e-mail at: *CoP15@fws.gov*, or via fax at: 703–358–2298. Comments pertaining to species proposals should be sent to the Division of Scientific Authority, U.S. Fish and Wildlife Service, 4401 North Fairfax Drive, Room 110, Arlington, VA 22203, or via e-mail at: *scientificauthority@fws.gov*, or via fax at: 703–358–2276.

FOR FURTHER INFORMATION CONTACT: For information pertaining to resolutions, decisions, and agenda items contact: Robert R. Gabel, Chief, Division of Management Authority, phone 703–358–2095, fax 703–358–2298, e-mail: *CoP15@fws.gov*. For information pertaining to species proposals contact: Rosemarie Gnam, Chief, Division of Scientific Authority, phone 703–358–1708, fax 703–358–2276, e-mail: *scientificauthority@fws.gov*.

SUPPLEMENTARY INFORMATION:

Background

The Convention on International Trade in Endangered Species of Wild Fauna and Flora, hereinafter referred to as CITES or the Convention, is an international treaty designed to control and regulate international trade in certain animal and plant species that are now or potentially may be threatened with extinction. These species are listed in Appendices to CITES, which are available on the CITES Secretariat's website at *http://www.cites.org/eng/app/index.shtml*. Currently, 175 countries, including the United States, are Parties to CITES. The Convention calls for biennial meetings of the Conference of the Parties, which reviews its implementation, makes provisions enabling the CITES Secretariat in Switzerland to carry out its functions, considers amendments to the lists of species in Appendices I and II, considers reports presented by the Secretariat, and makes recommendations for the improved effectiveness of CITES. Any country that is a Party to CITES may propose for these meetings amendments to Appendices I and II, and resolutions, decisions, and agenda items for consideration by all the Parties.

This is our second in a series of **Federal Register** notices that, together with an announced public meeting, provide you with an opportunity to participate in the development of the U.S. negotiating positions for the fifteenth regular meeting of the Conference of the Parties to CITES (CoP15). We published our first CoP15-related **Federal Register** notice on September 29, 2008 (73 FR 56605), in which we requested information and recommendations on species proposals and proposed resolutions, decisions, and agenda items for the United States to consider submitting for consideration at CoP15. You may obtain information on that **Federal Register** notice from the following sources: for information on proposed resolutions, decisions, and agenda items, contact the Division of Management Authority at the address provided in ''**ADDRESSES**'' above; and for information on species proposals, contact the Division of Scientific Authority at the address provided in ''**ADDRESSES**'' above. Our regulations governing this public process are found in 50 CFR 23.87.

CoP15 is tentatively scheduled to be held in Doha, Qatar, March 13–25, 2010.

I. Recommendations for Resolutions, Decisions, and Agenda Items for the United States To Consider Submitting for CoP15

In our **Federal Register** notice published on September 29, 2008 (73 FR 56605), we requested information and recommendations on potential resolutions, decisions, and agenda items for the United States to submit for consideration at CoP15. We received recommendations for resolutions, decisions, and agenda items from the following organizations: the Species Survival Network (SSN); TRAFFIC; the Whale and Dolphin Conservation Society (WDCS); and the World Wide Fund for Nature (WWF). We also received a comment from one individual.

We considered all of the recommendations of the above individual and organizations, as well as the factors described in the U.S. approach for CoP15 discussed in our September 29, 2008, **Federal Register** notice, when compiling a list of resolutions, decisions, and agenda items that the United States is likely to submit for consideration by the Parties at CoP15; and lists of resolutions, decisions, and agenda items for consideration at CoP15 that the United States either is currently undecided about submitting, is not considering submitting at this time, or plans to address in other ways. The United States may consider submitting documents for some of the issues for which it is currently undecided or not considering submitting at this time, depending on the outcome of discussions of these issues in the CITES Animals, Plants, and Standing Committees, or additional consultations with range country governments and subject matter experts.

Please note that, in sections A, B, and C below, we have listed those resolutions, decisions, and agenda items that the United States is likely to submit, currently undecided about submitting, or currently planning not to submit. We have posted an extended version of this notice on our website at *http://www.fws.gov/international/newspubs/fedregnot.html*, with text describing in more detail each of these issues and explaining the rationale for the tentative U.S. position on each issue. Copies of the extended version of the notice are also available from the Division of Management Authority at the above address.

We welcome your comments and information regarding the resolutions, decisions, and agenda items that the United States is likely to submit, currently undecided about submitting, or currently planning not to submit.

A. What resolutions, decisions, and agenda items is the United States likely to submit for consideration at CoP15?

1. A document that continues to support a strong stance on tiger conservation and efforts to address illegal trade in tiger and other Asian big cat parts and derivatives in both range and consumer countries.

2. A discussion document addressing inconsistent implementation of Appendix-III timber listings annotated to include only the national populations of the listing countries, and possibly including a proposal to amend Resolution Conf. 9.25 (Rev. CoP14), by deleting Recommendation a) iv), regarding the inclusion of geographically separate populations of timber species in Appendix III, and adding language to direct the CITES Secretariat to consult with countries who request such listings to ensure that the listings will achieve the level of control and cooperation with other range countries intended.

3. A discussion document addressing difficulties encountered associated with the reporting of scientific names for CITES-listed coral specimens, including proposed changes to Resolution Conf. 12.3 (Rev. CoP14) to indicate that taxonomic names of corals on CITES permits and certificates should comply with the list in CITES Notification to the Parties No. 2003/020, and a draft decision directing the Animals Committee to update the list in Notification No. 2003/020.

B. On what resolutions, decisions, and agenda items is the United States still undecided, pending additional information and consultations?

1. A discussion document on how CITES might incorporate impacts of climate change in future deliberations, or how Parties could incorporate climate change resilience into their non-detriment findings.

2. A discussion document on the conservation issues associated with and management of the snake trade in Asia.

3. A discussion document raising possible problems with the current guidelines to register and monitor operations that breed Appendix-I animal species for commercial purposes provided in Resolution Conf. 12.10 (Rev. CoP14), and possibly including a proposal to amend this resolution.

C. What resolutions, decisions, and agenda items is the United States not likely to submit for consideration at CoP15, unless we receive significant additional information?

1. A resolution that details the need to accurately and adequately describe on CITES permits and in CITES annual reports both the types of specimens in trade and the quantities of specimens in trade.

2. A document expressing disappointment in the lack of progress that has been made to date in the development and implementation of regional management plans for the African grey parrot (*Psittacus erithacus*).

3. A document related to the establishment of ''zero export quotas'' for those species subject to a Standing Committee recommendation to suspend trade.

4. A document emphasizing the importance of sound science in the making of CITES non-detriment findings for the import of specimens included in Appendix I, and export of specimens of species included in Appendices I and II.

II. Recommendations for Species Proposals for the United States To Consider Submitting for CoP15

In our **Federal Register** notice of September 29, 2008 (73 FR 56605), we requested information and recommendations on potential species proposals for the United States to consider submitting for consideration at CoP15. We received recommendations from the following organizations for possible proposals involving 46 taxa (5 families, 7 genera, and 34 individual species) and 5 general animal groups (furbearers, ungulates, freshwater turtles, sharks, and other fish): the Animal Welfare Institute; Defenders of Wildlife; the Humane Society of the United States (HSUS); Humane Society International (HSI); the International Union for Conservation of Nature Species Survival Commission (IUCN/SSC) Tortoise and Freshwater Turtle Specialist Group; the Mid-Atlantic Turtle and Tortoise Society; the Ocean Conservancy; the Pew Institute for Ocean Conservation Science; Sea Web; SSN; TRAFFIC; WDCS; and WWF. We have undertaken initial assessments of the available trade and biological information on all of these taxa. Based on these assessments, we made provisional determinations of whether to proceed with the development of proposals to list or delist species, or transfer them from one Appendix to another. We made these determinations by considering the quality of biological and trade information available on the

species; the presence, absence, and effectiveness of other mechanisms that may preclude the need for a CITES listing (e.g., range country actions or other international agreements); and availability of resources. Furthermore, our assignment of a taxon to one of these categories, which reflects the likelihood of our submitting a proposal, included consideration of the following factors, which reflect the U.S. approach for CoP15 discussed in our September 29, 2008, **Federal Register** notice:

(1) Is it a native U.S. species that is or may be significantly affected by trade, or if it is a currently listed U.S. species, does the listing accurately reflect the biological and trade status of the species?

(2) Is it a native U.S. species that is not at this time significantly impacted by trade within the United States, but is being significantly impacted elsewhere in its range?

(3) Is it a foreign species, not native to the United States, but which is or may be significantly affected by trade, and the United States is a significant component of the trade (i.e., as an importing country)?

(4) Is it a species for which the United States is neither a range country nor a country significantly involved in trade, but for which trade is a serious threat to the continued existence of the species, other mechanisms are lacking or ineffective for bringing trade under control, and action is urgently needed?

In sections A, B, and C below, we have listed the current status of each species proposal recommended by the public, as well as species proposals we have been developing on our own. Please note that we have only provided here a list of taxa and the proposed action. We have posted an extended version of this notice on our website at *http://www.fws.gov/international/newspubs/fedregnot.html*, with text describing in more detail each proposed action and explaining the rationale for the tentative U.S. position on each possible proposal. Copies of the extended version of the notice are also available from the Division of Management Authority at the above address.

We welcome your comments, especially if you are able to provide any additional biological or trade information on these species. For each species, more detailed information is on file in the Division of Scientific Authority.

A. What species proposals is the United States likely to submit for consideration at CoP15?

The United States is likely to develop and submit proposals for the following taxa. For some of the species below, particularly those not native to the United States, additional consultations with range countries and subject matter experts are proceeding, and final decisions are pending, based on the outcomes of those consultations and any additional information received.

Plants

1. Flasked seedlings – Amendment of the annotation for Appendix-I orchid species to make it consistent with the language in Resolution Conf. 11.11 (Rev. CoP14) pertaining to flasked seedlings

Corals

2. Red and pink coral (*Corallium* spp. and *Paracorallium* spp.) – Inclusion in Appendix II

Mammals

3. Bobcat (*Lynx rufus*) – Removal from Appendix II

B. On what species proposals is the United States still undecided, pending additional information and consultations?

The United States is still undecided on whether to submit proposals for CoP15 for the following taxa. In some cases, we have not completed our consultations with relevant range countries. In other cases, we expect meetings to occur in the immediate future at which participants will generate important recommendations, trade analyses, or biological information on the taxon in question.

Plants

1. Cedars (*Cedrela* spp.) – Inclusion in Appendix II
2. Cliff spurge (*Euphorbia misera*) – Removal from Appendix II

Mollusks

3. Nautilids (*Allonautilus* spp. and *Nautilus* spp.) – Inclusion in Appendix II

Fish

4. Tope shark (*Galeorhinus galeus*) – Inclusion in Appendix II
5. Shortfin mako shark (*Isurus oxyrhinchus*) – Inclusion in Appendix II
6. Longfin mako shark (*Isurus paucus*) – Inclusion in Appendix II
7. Porbeagle shark (*Lamna nasus*) – Inclusion in Appendix II
8. Freshwater sawfish (*Pristis microdon*) – Transfer from Appendix II to Appendix I
9. Hammerhead sharks (*Sphyrna* spp.) – Inclusion in Appendix II
10. Spiny dogfish (*Squalus acanthias*) – Inclusion in Appendix II
11. Requiem sharks (Carcharinidae) - Inclusion in Appendix II
12. Devil and manta rays (Mobulidae) – Inclusion in Appendix II
13. Freshwater stingrays (Potamotrygonidae) – Inclusion in Appendix II
14. American eel (*Anguilla rostrata*) – Inclusion in Appendix II
15. Northern bluefin tuna (*Thunnus thynnus*) – Inclusion in Appendix I

Reptiles

16. Common snapping turtle (*Chelydra serpentina*) – Inclusion in Appendix III (Note: The IUCN/SSC Tortoise and Freshwater Turtle Specialist Group recommended that the United States propose inclusion of the common snapping turtle in Appendix III at CoP15, although inclusion of a species in Appendix III is a unilateral decision and does not require a proposal to be brought forward to the CoP)
17. Spotted turtle (*Clemmys guttata*) – Inclusion in Appendix II
18. Diamondback terrapin (*Malaclemys terrapin*) – Inclusion in Appendix II
19. Florida soft-shell turtle (*Apalone ferox*) – Inclusion in Appendix II
20. Smooth soft-shell turtle (*Apalone mutica*) – Inclusion in Appendix II
21. Spiny soft-shell turtle (*Apalone spinifera*) – Inclusion in Appendix II
22. Giant leaf-tailed gecko (*Uroplatus giganteus*) – Transfer from Appendix II to Appendix I

Mammals

23. Polar bear (*Ursus maritimus*) – Transfer from Appendix II to Appendix I
24. Walrus (*Odobenus rosmarus*) – Inclusion in Appendix II
25. Narwhal (*Monodon monoceros*) – Transfer from Appendix II to Appendix I

C. What species proposals is the United States not likely to submit for consideration at CoP15, unless we receive significant additional information?

The United States does not intend to submit proposals for the following taxa unless we receive significant additional information indicating that a proposal is warranted. Information currently available for each of the taxa listed below does not support a defensible listing proposal. In addition to the taxa listed below, please note that the Animal Welfare Institute provided us with a tentative list of taxonomic groups

of animal species for which it was recommending that the United States consider amendments to the Appendices. These groups of species included ''native and non-native species including freshwater turtles, sharks, furbearers, fish, and ungulates.'' We do not have the resources to evaluate such a broad request in the timeframes necessary for decision making for CoP15. Therefore, the United States does not intend to submit any proposals to the CoP as a result of this recommendation.

Fish

1. Gulper sharks (Centrophoridae) – Inclusion in Appendix II
2. Guitarfishes and shovelnose rays (Rhinobatidae) – Inclusion in Appendix II
3. Beluga sturgeon (*Huso huso*) – Transfer from Appendix II to Appendix I

Amphibians

4. Blue-sided frog (*Agalychnis annae*) – Inclusion in Appendix II
5. Morelet's tree frog (*Agalychnis moreletii*) – Inclusion in Appendix II
6. Rancho Grande harlequin frog (*Atelopus cruciger*) – Inclusion in Appendix II
7. Helmeted water toad (*Caudiverbera caudiverbera*) – Inclusion in Appendix II
8. Santa Fe frog (*Leptodactylus laticeps*) – Inclusion in Appendix II
9. Giant Asian river frog (*Limnonectes blythii*) – Inclusion in Appendix II
10. Fanged river frog (*Limnonectes macrodon*) – Inclusion in Appendix II
11. Giant Philippine frog (*Limnonectes magnus*) – Inclusion in Appendix II
12. Albanian water frog (*Rana shqiperica*) – Inclusion in Appendix II
13. Rain frog (*Scaphiophryne boribory*) – Inclusion in Appendix II
14. Alto Verapaz salamander (*Bolitoglossa dofleini*) – Inclusion in Appendix II
15. Kaiser's spotted newt (*Neurergus kaiseri*) – Inclusion in Appendix I or II
16. Kurdistan newt (*Neurergus microspilotus*) – Inclusion in Appendix II

Reptiles

17. Alligator snapping turtle (*Macrochelys temminckii*) – Inclusion in Appendix II
18. Map turtles (*Graptemys* spp.) – Inclusion in Appendix II

In addition to the taxa listed above, Defenders of Wildlife and SSN suggested that more research be done on *Limnonectes* spp. frogs and the Laos wart newt (*Paramesotriton laoensis*). We need additional biological and trade information for both taxa to determine whether they meet the listing criteria in CITES Resolution Conf. 9.24 (Rev. CoP14).

Request for Information and Comments

We invite any information and comments concerning any of the possible CoP15 species proposals and proposed resolutions, decisions, and agenda items discussed above. You must submit your information and comments to us no later than the date specified in ''DATES'' above, to ensure that we consider them. Comments and materials received will be available for public inspection, by appointment, from 8 a.m. to 4 p.m., Monday through Friday, at either the Division of Management Authority or the Division of Scientific Authority. Our practice is to make comments, including names and home addresses of respondents, available for public review during regular business hours. Individual respondents may request that we withhold their home addresses from the administrative record, which we will honor to the extent allowable by law. There also may be circumstances in which we would withhold from the administrative record a respondent's identity, as allowable by law. If you wish to withhold your name and/or address, you must state this prominently at the beginning of your comment. We will make all comments and materials submitted by organizations or businesses, and by individuals identifying themselves as representatives or officials of organizations or businesses, available for public inspection in their entirety.

Observers

Article XI, paragraph 7 of CITES states the following:

''Any body or agency technically qualified in protection, conservation or management of wild fauna and flora, in the following categories, which has informed the Secretariat of its desire to be represented at meetings of the Conference by observers, shall be admitted unless at least one-third of the Parties present object:

(a) international agencies or bodies, either governmental or non-governmental, and national governmental agencies and bodies; and

(b) national non-governmental agencies or bodies which have been approved for this purpose by the State in which they are located.

Once admitted, these observers shall have the right to participate but not to vote.''

Persons wishing to be observers representing international nongovernmental organizations (which must have offices in more than one country) at CoP15 may request approval directly from the CITES Secretariat. Persons wishing to be observers representing U.S. national nongovernmental organizations at CoP15 must receive prior approval from our Division of Management Authority. Once we grant our approval, a U.S. national nongovernmental organization is eligible to register with the Secretariat and must do so at least 6 weeks prior to the opening of CoP15 to participate in CoP15 as an observer. Individuals who are not affiliated with an organization may not register as observers. An international nongovernmental organization with at least one office in the United States may register as a U.S. nongovernmental organization if it prefers.

A request submitted to us for approval as an observer should include evidence of technical qualifications in protection, conservation, or management of wild fauna and/or flora, on the part of both the organization and the individual representative(s). The request should also include copies of the organization's charter and/or bylaws, and a list of representatives it intends to send to CoP15. Organizations seeking approval for the first time should detail their experience in the protection, conservation, or management of wild fauna and/or flora, as well as their purposes for wishing to participate in CoP15 as an observer. An organization that we have previously approved as an observer at a meeting of the Conference of the Parties within the past 5 years must submit a request, but does not need to provide as much detailed information concerning its qualifications as an organization seeking approval for the first time. These requests should be sent to the Division of Management Authority (see ''**ADDRESSES**,'' above).

Once we approve an organization as an observer, we will send the organization instructions for registration with the CITES Secretariat in Switzerland, including a meeting registration form and travel and hotel information. A list of organizations approved for observer status at CoP15 will be available upon request from the Division of Management Authority just prior to the start of CoP15.

Future Actions

We expect the CITES Secretariat to provide us with a provisional agenda for CoP15 within the next several months. Once we receive the provisional agenda,

we will publish it in a **Federal Register** notice and provide the Secretariat's website URL. We will also provide the provisional agenda on our website at *http://www.fws.gov/international*.

The United States will submit any species proposals, and proposed resolutions, decisions, and agenda items for consideration at CoP15 to the CITES Secretariat 150 days prior to the start of the meeting (i.e., tentatively by mid–October , 2009). We will consider all available information and comments, including those received in writing during the comment period, as we decide which species proposals, and proposed resolutions, decisions, and agenda items warrant submission by the United States for consideration by the Parties. Approximately 4 months prior to CoP15, we will post on our website an announcement of the species proposals, and proposed resolutions, decisions, and agenda items submitted by the United States to the CITES Secretariat for consideration at CoP15.

Through an additional notice and website posting in advance of CoP15, we will inform you about preliminary negotiating positions on resolutions, decisions, and amendments to the Appendices proposed by other Parties for consideration at CoP15. We will also publish an announcement of a public meeting tentatively to be held approximately 2 months prior to CoP15, to receive public input on our positions regarding items submitted by other Parties.

Author

The primary authors of this notice are Mark Albert, Division of Management Authority; and Pamela Hall, Division of Scientific Authority; under the authority of the U.S. Endangered Species Act of 1973, as amended (16 U.S.C. 1531 *et seq*.).

Dated: June 29, 2009

Marvin Moriarty

Acting Deputy Director

[FR Doc. E9–16410 Filed 7–10– 09; 8:45 am]

BILLING CODE 4310–55–S

DEPARTMENT OF THE INTERIOR

National Park Service

National Register of Historic Places; Notification of Pending Nominations and Related Actions

Nominations for the following properties being considered for listing or related actions in the National Register were received by the National Park Service before July 4, 2009. Pursuant to § 60.13 of 36 CFR Part 60 written comments concerning the significance of these properties under the National Register criteria for evaluation may be forwarded by United States Postal Service, to the National Register of Historic Places, National Park Service, 1849 C St., NW., 2280, Washington, DC 20240; by all other carriers, National Register of Historic Places, National Park Service, 1201 Eye St., NW., 8th floor, Washington, DC 20005; or by fax, 202–371–6447. Written or faxed comments should be submitted by July 28, 2009.

J. Paul Loether,

Chief, National Register of Historic Places/ National Historic Landmarks Program.

ALABAMA

Jefferson County

Belcher-Nixon Building, 1728 29th St. Ensley, Birmingham, 09000603

Downtown Ensley Historic District, 17th-21st Sts. Ensley & Avenues C–H, Birmingham, 09000604

Lee County

Darden, Dr. J.W., House, 1323 Auburn St., Opelika, 09000605

Monroe County

Monroeville Downtown Historic District, Parts of N. and S. Alabama Aves., E. and W. Claiborne St., N. and S. Mount Pleasant Aves., Pineville Rd., Monroeville, 09000606

Winston County

Feldman's Department Store, 800 20th St., Haleyville, 09000607

ARIZONA

Cochise County

Schilling Ranch Historic District, (Cattle Ranching in Arizona in the Modern Era, 1945–1970) 6396 N. Schilling Ranch Rd., Corral, 09000608

Maricopa County

Bennitt Mansion, 126 E. County Club Dr., Phoenix, 09000609

IOWA

Guthrie County

Garst, Roswell and Elizabeth, Farmstead Historic District, 1390 IA 141, Coon Rapids, 09000610

MASSACHUSETTS

Essex County

Samuel Brown School, 200 Lynn St., Peabody, 09000611

Suffolk County

Evergreen Cemetery, 2060 Commonwealth Ave., Boston, 09000612

VIRGINIA

Bedford County

Liberty Hall, 12000 E. Lynchburg Salem Turnpike, Forest, 09000613

Fauquier County

Orlean Historic District, Area including parts of John Barnton Payne and Leeds Manor Rds., Orlean, 09000615

Woodside, 9525 Maidstone Rd., Delaplane, 09000616

Goochland County

First Union School (Rosenwald Schools in Virginia MPS), 1522 Old Mill Rd., Crozier, 09000614

Salem Independent city

Valley Railroad Bridge, 1002 Newman Dr., Salem, 09000617

[FR Doc. E9–16421 Filed 7–10–09; 8:45 am]

BILLING CODE P

DEPARTMENT OF THE INTERIOR

National Park Service

National Register of Historic Places; Weekly Listing of Historic Properties

Pursuant to (36 CFR 60.13(b, c)) and (36 CFR 63.5), this notice, through publication of the information included herein, is to apprise the public as well as governmental agencies, associations and all other organizations and individuals interested in historic preservation, of the properties added to, or determined eligible for listing in, the National Register of Historic Places from May 18, to May 22, 2009.

For further information, please contact Edson Beall via: United States Postal Service mail, at the National Register of Historic Places, 2280, National Park Service, 1849 C St., NW., Washington, DC 20240; in person (by appointment), 1201 Eye St., NW., 8th floor, Washington, DC 20005; by fax, 202–371–2229; by phone, 202–354–2255; or by e-mail, *Edson_Beall@nps.gov*.

Dated: July 7, 2009.

J. Paul Loether,

Chief, National Register of Historic Places/ National Historic Landmarks Program.

KEY: State, County, Property Name, Address/Boundary, City, Vicinity, Reference Number, Action, Date, Multiple Name

ARIZONA

Maricopa County

McCullough-Price House, 300 S. Chandler Village Dr., Chandler, 09000311, LISTED, 5/20/09

ARKANSAS

Phillips County

Battery D (Boundary Increase), Address Restricted, Helena-West Helena, 09000317, LISTED, 5/20/09

Poinsett County

Highway A–7, Ditch No. 6 Bridge, E. Davis St. over Ditch No. 6 SE. of Steel Bridge Rd.,

Tyronza, 09000319, LISTED, 5/20/09 (Historic Bridges of Arkansas MPS)

Poinsett County

Highway A–7, Tyronza Segment, old US 63 between Memphis Ave. and the Tyronza River, Tyronza, 09000320, LISTED, 5/20/09 (Arkansas Highway History and Architecture MPS)

Pulaski County

Mitchell, James, School, 2410 S. Battery St., Little Rock, 09000322, LISTED, 5/20/09

Pulaski County

Smith, Morgan, Dr., House, 5110 Stagecoach Rd., Little Rock, 09000323, LISTED, 5/20/09

St. Francis County

Highway B–1, Little Telico Creek Bridge, SFC 213 Rd. over Little Telico Creek, Caldwell, 09000316, LISTED, 5/20/09 (Historic Bridges of Arkansas MPS)

CALIFORNIA

Los Angeles County

Brockman Building and New York Cloak and Suit House (annex), 520 W. 7th St. and 708 S. Grand Ave., Los Angeles, 08001276, LISTED, 5/21/09

FLORIDA

Lake County

Witherspoon Lodge No. 111 Free and Accepted Masons (F&AM), 1410 N. Clayton St., Mount Dora, 09000346, LISTED, 5/21/09 (Mount Dora, FL)

GEORGIA

Cobb County

Pace, Solomon and Penelopy, House, 3057 Paces Mill Rd., Vinings, 09000325, LISTED, 5/20/09

Douglas County

Basket Creek Cemetery, 7829 Capps Ferry Rd., Douglasville vicinity, 09000326, LISTED, 5/20/09

Henry County

Hooten, James and Bertha, House, 115 Atlanta St., McDonough, 09000327, LISTED, 5/20/09

ILLINOIS

Cook County

Frank Lloyd Wright-Prairie School of Architecture Historic District (Boundary Increase), Roughly bounded by Division St. on the N., N. Cuyler Ave. on the E., Lake St. on the S. and N. Harlem Ave on the W., Oak Park, 08001096, LISTED, 5/22/09

IOWA

Buchanan County

Malek Theatre, 116 2nd Ave. NE., Independence, 09000329, LISTED, 5/21/09

KANSAS

Crawford County

S–W Supply Company, 215 E. Prairie, Girard, 09000348, LISTED, 5/21/09

Jackson County

Holton Bath House, 711 Nebraska Ave., Holton, 09000351, LISTED, 5/21/09 (New Deal-Era Resources of Kansas MPS)

Sedgwick County

Smyser House, 931 Buffum Ave., Wichita, 09000353, LISTED, 5/21/09 (Residential Resources of Wichita, Sedgwick County, Kansas 1870–1957)

MISSOURI

Adair County

Kirksville Courthouse Square Historic District, 200 block N. Franklin St., 100 block E. Harrison St., 100 block W. Harrison St., Kirksville, 09000330, LISTED, 5/21/09

OKLAHOMA

Tulsa County

Atlas Life Building, 415 S. Boston Ave., Tulsa, 09000358, LISTED, 5/19/09

VIRGINIA

Caroline County

Grove, The, 33115 Mount Gideon Rd., Hanover vicinity, 09000333, LISTED, 5/21/09

Danville Independent City

Danville Tobacco Warehouse and Residential Historic District (Boundary Increase), 209 and 215 Main St., Danville, 09000334, LISTED, 5/21/09

Fairfax County

Woodlawn Quaker Meetinghouse, 8990 Woodlawn Rd., Fort Belvoir, 09000335, LISTED, 5/21/09

Fauquier County

Bristersburg Historic District, Area including parts of Elk Run and Bristersburg Rds., Bristersburg, 09000336, LISTED, 5/21/09

Fauquier County

Sumerduck Historic District, Area including parts of Sumerduck Rd., Sumerduck, 09000337, LISTED, 5/21/09

Patrick County

Barnard Farm, 2878 VA 648, Ararat vicinity, 09000338, LISTED, 5/21/09

WASHINGTON

Pierce County

American Lake Veterans Hospital, 9600 Veterans Dr., SW., Tacoma, 09000218, LISTED, 5/19/09

WISCONSIN

Heboygan County

Byron (schooner) Shipwreck, Address Restricted, Oostburg vicinity, 09000368, LISTED, 5/20/09 (Great Lakes Shipwreck Sites of Wisconsin MPS)

[FR Doc. E9–16419 Filed 7–10–09; 8:45 am]

BILLING CODE 4310–70–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[LLNM920000 L13100000 FI0000; NMNM–119264]

Notice of Proposed Reinstatement of Terminated Oil and Gas Lease NMNM 119264

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of Reinstatement of Terminated Oil and Gas Lease.

SUMMARY: Under the Class II provisions of Title IV, Public Law 97–451, the Bureau of Land Management (BLM) received a petition for reinstatement of oil and gas lease NMNM 119264 from the lessee, J Bar Cane Inc., for lands in Chaves County, New Mexico. The petition was filed on time and was accompanied by all the rentals due since the date the lease terminated under the law.

FOR FURTHER INFORMATION CONTACT: Lourdes B. Ortiz, Bureau of Land Management, New Mexico State Office, P.O. Box 27115, Santa Fe, New Mexico 87502 or at (505) 438–7586.

SUPPLEMENTARY INFORMATION: No valid lease has been issued that affects the lands. The lessee agrees to new lease terms for rentals and royalties of $10.00 per acre or fraction thereof, per year, and 16⅔ percent, respectively. The lessee paid the required $500.00 administrative fee for the reinstatement of the lease and $166.00 cost for publishing this Notice in the **Federal Register**. The lessee met all the requirements for reinstatement of the lease as set out in sections 31(d) and (e) of the Mineral Leasing Act of 1920 (30 U.S.C. 188). We are proposing to reinstate lease NMNM 119264, effective the date of termination, December 1, 2008, under the original terms and conditions of the lease and the increased rental and royalty rates cited above.

Lourdes B. Ortiz,

Land Law Examiner, Fluids Adjudication Team.

[FR Doc. E9–16418 Filed 7–10–09; 8:45 am]

BILLING CODE 4310–FB–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[LLCON04000–L12200000–PA0000]

Notice of Proposed Supplementary Rules for Public Lands in Colorado: McInnis Canyons National Conservation Area

AGENCY: Bureau of Land Management, Department of the Interior.

ACTION: Proposed supplementary rules.

SUMMARY: The Bureau of Land Management's (BLM) Grand Junction Field Office is proposing supplementary rules to regulate conduct on public lands within the McInnis Canyons National Conservation Area (MCNCA). These supplementary rules are needed to implement decisions found in the McInnis Canyons National Conservation Area Resource Management Plan to protect public health, safety, lands and resources.

DATES: Comments on the proposed supplementary rules must be received or postmarked by September 11, 2009 to be assured consideration. The BLM is not obligated to consider comments postmarked or received after this date.

ADDRESSES: Please mail comments to Katie Stevens, McInnis Canyons National Conservation Area, 2815 H Road, Grand Junction, Colorado 81506; or e-mail comments to *gjfo_webmail@blm.gov,* Attn: ''McInnis Canyons.''

FOR FURTHER INFORMATION CONTACT: Katie Stevens, McInnis Canyons National Conservation Area, (970) 244–3049, e-mail: *Katie_A_Stevens@blm.gov* or Eric Boik, BLM Field Staff Law Enforcement Ranger, (970) 244–3070, e-mail: *Eric_Boik@blm.gov*

SUPPLEMENTARY INFORMATION:

I. Public Comment Procedures

Written comments on the proposed supplementary rules should be specific, be confined to issues pertinent to the proposed supplementary rules, and explain the reason for any recommended change. Where possible, comments should reference the specific section or paragraph of the proposal which the comment is addressing. The BLM is not obligated to consider or include in the Administrative Record for the final supplementary rules comments either postmarked or electronically dated after the deadline or delivered to an address other than the address listed above (*See* **ADDRESSES**).

Comments (including names, street addresses, and other contact information of respondents) will be available for public review at 2815 H Road, Grand Junction, Colorado 81506. Before including your address, phone number, e-mail address, or other personal identifying information in your comment, you should be aware that your entire comment—including your personal identifying information—may be made publicly available at any time. While you can ask us in your comment to withhold your personal identifying information from public review, we cannot guarantee that we will be able to do so.

II. Background

These proposed supplementary rules apply to the McInnis Canyons National Conservation Area (MCNCA), approximately 122,300 acres of public lands which include the 75,550 acre Black Ridge Canyons Wilderness. The MCNCA, originally known as the Colorado Canyons National Conservation Area, was established by Public Law 106–353 on October 24, 2000. It was renamed for Representative Scott McInnis by Public Law 108–400 on January 1, 2005.

The MCNCA is located 10 miles west of Grand Junction, Colorado and is bordered by the Colorado National Monument to the east and the Colorado/Utah state line to the west. A small portion of the Black Ridge Canyons Wilderness (5,200 acres) extends into Grand County, Utah. The proposed supplementary rules will help the BLM achieve management objectives and implement decisions in the MCNCA Resource Management Plan (RMP) approved on October 24, 2004.

III. Discussion of the Proposed Supplementary Rules

In preparing the RMP, the BLM sought public review of four alternatives and then approved adaptive management, its preferred alternative. Adaptive management allows for flexibility in management actions based on the results of resource and visitor monitoring.

The RMP includes specific management actions that restrict certain activities and define allowable uses. The proposed supplementary rules implement these management actions within the MCNCA. Many of the proposed supplementary rules apply to the entire area, but some apply only to specific areas within the NCA. The proposed supplementary rules are written to allow for adaptive management.

IV. Procedural Matters

Executive Order 12866, Regulatory Planning and Review

The supplementary rules do not comprise a significant regulatory action and are not subject to review by the Office of Management and Budget under Executive Order 12866. The supplementary rules will not have an annual effect of $100 million or more on the economy. They will not adversely affect in a material way the economy, productivity, competition, jobs, the environment, public health or safety, or state, local, or tribal governments or communities. The supplementary rules will not create a serious inconsistency or otherwise interfere with an action taken or planned by another agency. The supplementary rules do not materially alter the budgetary effects of entitlements, grants, user fees, or loan programs or the rights or obligations of their recipients; nor do they raise novel legal or policy issues. The supplementary rules are merely rules of conduct for public use of a limited area of public lands.

Clarity of the Regulations

Executive Order 12866 requires each agency to write regulations that are simple and easy to understand. The BLM invites your comments on how to make the supplementary rules easier to understand, including answers to questions such as the following:

1. Are the requirements in the supplementary rules clearly stated?
2. Do the supplementary rules contain technical language or jargon that interferes with their clarity?
3. Does the format of the supplementary rules (grouping and order of sections, use of headings, paragraphing, etc.) aid or reduce clarity?
4. Is the description of the supplementary rules in the **SUPPLEMENTARY INFORMATION** section of this preamble helpful in understanding the supplementary rules? How could this description be more helpful in making the supplementary rules easier to understand?

Please send any comments you have on the clarity of the rule to the address specified in the **ADDRESSES** section.

National Environmental Policy Act

In July 2004, the BLM completed an environmental impact statement (EIS) as part of the development of the Proposed Resource Management Plan and Final Environmental Impact Statement for the Colorado Canyons National Conservation Area and Black Ridge Canyons Wilderness (now McInnis Canyons National Conservation Area).

During the National Environmental Policy Act process, many proposed decisions were fully analyzed, including the substance of these supplementary rules. The pertinent analysis can be found in Chapter 2, Alternatives, of the Resource Management Plan (RMP). The Record of Decision for the RMP was signed by the BLM State Director of Colorado in October 2004. These proposed supplementary rules provide for enforcement of decisions in the RMP. The rationale for the decisions made in the plan is fully covered in the EIS. The EIS is available for review in the BLM administrative record at the address specified in the **ADDRESSES** section.

Regulatory Flexibility Act

Congress enacted the Regulatory Flexibility Act (RFA) of 1980, as amended (5 U.S.C. 601–612) to ensure that government regulations do not unnecessarily or disproportionately burden small entities. The RFA requires a regulatory flexibility analysis if a rule would have a significant economic impact, either detrimental or beneficial, on a substantial number of small entities. The supplementary rules merely establish rules of conduct for public use of a limited area of public lands. Therefore, the BLM has determined under the RFA that the supplementary rules would not have a significant economic impact on a substantial number of small entities.

Small Business Regulatory Enforcement Fairness Act

The supplementary rules are not considered a major rule as defined under 5 U.S.C. 804(2). The supplementary rules merely establish rules of conduct for public use of a limited area of public lands and do not affect commercial or business activities of any kind.

Unfunded Mandates Reform Act

The supplementary rules do not impose an unfunded mandate on state, local, or tribal governments in the aggregate, or on the private sector of more than $100 million per year; nor do they have a significant or unique effect on small governments. The supplementary rules have no effect on governmental or tribal entities and would impose no requirements on any of these entities. The supplementary rules merely establish rules of conduct for public use of a limited selection of public lands and do not affect tribal, commercial, or business activities of any kind. Therefore, the BLM is not required to prepare a statement containing the information required by the Unfunded Mandates Reform Act (2 U.S.C. 1531 *et seq.*).

Executive Order 12630, Governmental Actions and Interference With Constitutionally Protected Property Rights (Takings)

The supplementary rules do not have significant takings implications, nor are they capable of interfering with Constitutionally-protected property rights. The supplementary rules merely establish rules of conduct for public use of a limited area of public lands and do not affect anyone's property rights. Therefore, the BLM has determined that these rules will not cause a taking of private property or require preparation of a takings assessment under this Executive Order.

Executive Order 13132, Federalism

These supplementary rules will not have a substantial direct effect on the states, the relationship between the national government and the states, nor the distribution of power and responsibilities among the various levels of government. These supplementary rules do not come into conflict with any state law or regulation. Therefore, under Executive Order 13132, the BLM has determined that these supplementary rules do not have sufficient Federalism implications to warrant preparation of a Federalism Assessment.

Executive Order 12988, Civil Justice Reform

Under Executive Order 12988, these supplementary rules will not unduly burden the judicial system and that they meet the requirements of sections 3(a) and 3(b)(2) of the Order.

Executive Order 13175, Consultation and Coordination With Indian Tribal Governments

In accordance with Executive Order 13175, these supplementary rules do not include policies that have tribal implications. The supplementary rules do not affect land held for the benefit, nor impede the rights of Indians or Alaska Natives.

Paperwork Reduction Act

These proposed supplementary rules do not directly provide for any information collection that the Office of Management and Budget must approve under the Paperwork Reduction Act, 44 U.S.C. 3501 *et seq.* Any information collection that may result from Federal criminal investigations or prosecution conducted under these proposed supplementary rules is exempt from the provisions of the Paperwork Reduction Act of 1995, 44 U.S.C. 3518(c)(1).

Author

The principal author of these proposed supplementary rules is Eric Boik, BLM Field Staff Law Enforcement Ranger, McInnis Canyons National Conservation Area, 2815 H Road Grand Junction, Colorado 81506.

For the reasons stated in the preamble and under the authorities for supplementary rules found under 43 U.S.C. 1740 and 43 CFR 8365.1–6, the Colorado State Director, Bureau of Land Management, proposes supplementary rules for public lands managed by the BLM in Colorado, to read as follows:

Supplementary Rules for McInnis Canyons

1. These supplementary rules apply, except as specifically exempted, to activities within the McInnis Canyons National Conservation Area (MCNCA), which is comprised of public lands administered by the Bureau of Land Management near Grand Junction, Colorado.

2. These supplementary rules are in effect on a year-round basis and will remain in effect until modified by the authorized officer.

3. You must not camp in sites or areas not designated as open to camping by a BLM sign or map.

4. You must not start or maintain a fire in sites or areas not designated as open for such use by a BLM sign or map.

5. In areas designated as open for starting or maintaining a fire, any fire must be fully contained in a metal fire grate, fire pan, or other metal device to contain ashes. Mechanical stoves and other appliances that are fueled by gas, and equipped with a valve that allows the operator to control the flame, are among the devices that meet this requirement.

6. When starting or maintaining a fire outside of a developed recreation site, you must contain and completely remove fire ashes and debris from BLM land.

7. You must not cut, collect, or use live, dead, or down wood except in areas designated as open to such use by a BLM sign or map.

8. The hours of operation are sunrise to sunset in any area that is for day-use only as indicated by a BLM sign or map. You must not enter or remain in such an area after sunset or before sunrise.

9. You must not park in areas not designated for parking by a BLM sign or map.

10. Exceeding group size limits, as indicated by a BLM sign or map, is prohibited.

11. Exceeding length of stay limits, as indicated by a BLM sign or map, is prohibited.

12. Individuals and/or groups must register and possess proof of registration as indicated by a BLM sign or map.

13. You must not use roads and/or trails by motorized or mechanized vehicle or equestrian or pedestrian travel except where designated as open to such use by a BLM sign or map.

14. You must not discharge a firearm of any kind, including those used for target shooting or paintball. Licensed hunters in legitimate pursuit of game during the proper season with appropriate firearms, as defined by the Colorado Division of Wildlife, are exempt from this rule.

15. You must not collect or disturb rocks, minerals, fossils, chipped rocks, arrowheads, or other paleontological, prehistoric or historical artifacts.

16. You must not enter an area that is designated as closed by a BLM sign or map.

17. You must remove and properly dispose of canine solid waste when and where indicated by a BLM sign or map.

18. You must not bring any dog into the MCNCA that is not controlled by visual, audible, or physical means.

19. You must not burn material, including wood, that contains nails, glass, or any metal.

20. You must dispose of solid human waste as indicated by a BLM sign or map.

Exemptions: The following persons are exempt from these supplementary rules:

A. Any Federal, state, local and/or military personnel in the scope of their official duties;

B. Members of any organized rescue or fire-fighting force in performance of their official duties; and

C. Persons, agencies, municipalities, or companies holding an existing special-use permit inside the MCNCA and operating within the scope of their permit.

Penalties: Any person who violates any of these supplementary rules may be tried before a United States Magistrate and fined no more than $1,000 or imprisoned for no more than 12 months, or both. 43 U.S.C. 1733(a); 43 CFR 8360.0–7. Such violations may also be subject to the enhanced fines provided for by 18 U.S.C. 3571. In accordance with 43 CFR 8365.1–7, State or local officials may also impose penalties for violations of Colorado law.

Dave Hunsaker,

Associate State Director.

[FR Doc. E9–16416 Filed 7–10–09; 8:45 am]

BILLING CODE 4310–JB–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[LLNVC0200.L58740000.EU0000; N–82710, N–82711; 9–08807; TAS:14X5260]

Notice of Realty Action; Extension of Segregation of Public Lands for Proposed Sale in Lyon County, NV

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of realty action.

SUMMARY: This notice extends the segregation on 998.2 acres of public lands in Lyon County, Nevada for up to 2 additional years.

FOR FURTHER INFORMATION CONTACT: Fred Slagle, (775) 885–6115.

SUPPLEMENTARY INFORMATION: The following described public lands are located southwest (sec. 22) and south (sec. 36) of Fernley, Nevada:

Mount Diablo Meridian

T. 20 N., R. 24 E.,
Sec. 22, lots 1 to 6, inclusive, NE¼, E½NW¼, E½SW¼, and W½SE¼;
Sec. 36, E½NE¼NE¼, NW¼NE¼NE¼, N½NW¼NE¼, and W½.

The areas described aggregate 998.2 acres, more or less, in Lyon County.

Notification of a 2-year segregation of the described lands from appropriation under the public land laws, including the mining laws, except the sale provisions of the Federal Land Policy Management Act, appeared in the **Federal Register** on August 20, 2007 (72 FR 46509). The Bureau of Land Management (BLM) has completed an environmental analysis and by decision dated August 11, 2008, found the lands suitable for sale. The BLM has encountered unanticipated processing delays, including a pending action to clear an encumbrance on portions of the sale area. In accordance with 43 CFR 2711.1–2(d), the BLM Nevada State Director has determined that extension of this segregation is necessary to provide sufficient time to complete final processing steps required to offer these lands for sale. The segregative effect will terminate on issuance of a patent, publication in the **Federal Register** of a termination of the segregation, or on August 20, 2011, whichever occurs first.

(Authority: 43 CFR 2711.1–2(d))

Bryant Smith,

Associate District Manager, Carson City District.

[FR Doc. E9–16411 Filed 7–10–09; 8:45 am]

BILLING CODE 4310–HC–P

DEPARTMENT OF THE INTERIOR

Bureau of Indian Affairs

Restoration of Wilton Rancheria

AGENCY: Bureau of Indian Affairs, Interior.

ACTION: Notice.

SUMMARY: This notice is published pursuant to a court order and relates to restoration of the Wilton Miwok Rancheria, its members, and Dorothy Andrews, and the Me-Wuk Indian Community of the Wilton Rancheria. See the **SUPPLEMENTARY INFORMATION** section of this notice for details.

DATES: The restoration is effective as of June 8, 2009.

FOR FURTHER INFORMATION CONTACT: Jane Smith, Office of the Solicitor—Division of Indian Affairs, 1849 C Street, NW., MS–6456, Washington, DC 20240. Telephone: (202) 208–6526.

SUPPLEMENTARY INFORMATION: This notice is published pursuant to the Order issued June 8, 2009, in *Wilton Miwok Rancheria and Dorothy Andrews* v. *Salazar,* Civil No. C–07–02681 (JF) (PVT), and *Me-Wuk Indian Community of the Wilton Rancheria* v. *Salazar,* Civil No. C 07–05706 (JF), United States District Court for the Northern District of California.

Plaintiffs, Wilton Miwok Rancheria, its members, and Dorothy Andrews, and the Me-Wuk Indian Community of the Wilton Rancheria, hereinafter the Wilton Rancheria, are relieved from the application of section 10(b) of the Act of August 18, 1958, 72 Stat. 619, as amended by the Act of August 11, 1964, 78 Stat. 390, and shall be deemed entitled to any of the benefits or services provided or performed by the United States for Indians because of the status as Indian, if otherwise qualified under applicable laws and regulations.

The Wilton Rancheria is an Indian entity with the same status as it possessed prior to distribution of the assets of the Rancheria and shall be deemed entitled to any of the benefits or services provided or performed by the United States for Indian Tribes, bands, communities or groups because of its status as an Indian Tribe.

The Distribution Plan for the Wilton Rancheria is of no further force and effect and shall not be further

implemented, provided, however, that this provision shall not affect any vested rights created under the Distribution Plan.

Dated: July 1, 2009.

Paul Tsosie,

Acting Assistant Secretary—Indian Affairs.

[FR Doc. E9–16481 Filed 7–10–09; 8:45 am]

BILLING CODE 4310–4J–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[LLIDC0100000.L12200000.IA0000.241A.0; 4500007249]

Notice of Proposed Supplementary Rules for the Blue Creek Bay Public Lands Managed by the Coeur d'Alene Field Office, Kootenai County, ID

AGENCY: Bureau of Land Management, Interior.

ACTION: Proposed Supplementary Rules.

SUMMARY: The Bureau of Land Management (BLM) is proposing supplementary rules for use of 736 acres of public lands in and around Blue Creek Bay on Lake Coeur d'Alene. The proposed supplementary rules would implement decisions from the Blue Creek Bay Recreation Project Plan, approved January 7, 2009. The rules are necessary to protect public land natural resources and provide for the public's health and safety.

DATES: Comments on the proposed supplementary rules must be received in person or postmarked by August 12, 2009, to be assured consideration. In developing final supplementary rules, the BLM may not consider comments postmarked or received in person or by electronic mail after this date.

ADDRESSES: Mail or hand deliver all comments to the Bureau of Land Management, Coeur d'Alene Field Office, 3815 Schreiber Way, Coeur d'Alene, Idaho 83815 or e-mail comments to *brian_white@blm.gov.*

FOR FURTHER INFORMATION CONTACT: Eric R. Thomson, Field Manager, or Brian White, Outdoor Recreation Planner, Coeur d'Alene Field Office, 3815 Schreiber Way, Coeur d'Alene, Idaho 83815 or call (208) 769–5000.

SUPPLEMENTARY INFORMATION:

I. Public Comment Procedures

This notice and a map of the involved area are available for public review at the BLM Coeur d'Alene Field Office. You may mail or hand deliver comments to the Bureau of Land Management, Coeur d'Alene Field Office, 3815 Schreiber Way, Coeur d'Alene, Idaho 83815 during regular business hours from 7:45 a.m. to 4:30 p.m., Monday through Friday, except federal holidays; or e-mail comments to *brian_white@blm.gov.* Written comments on the proposed supplementary rules should be specific, confined to issues pertinent to the proposals, and explain the reason for any recommended change. Where possible, your comments should reference the specific section or paragraph of the proposal that you are addressing. The BLM may not necessarily consider or include comments in the administrative record for the final rule that are received after the comment period closes (see **DATES**) or comments delivered to an address other than that listed above (see **ADDRESSES**).

Comments, including names, street addresses, and other contact information of respondents, will be available for public review at 3815 Schreiber Way, Coeur d'Alene, Idaho 83815, during regular business hours.

Before including your address, telephone number, e-mail address, or other personal indentifying information in your comment, be advised that your entire comment—including your personal indentifying information—may be made publicly available at any time. While you can ask us in your comment to withhold from public review your personal identifying information, we cannot guarantee that we will be able to do so.

II. Background

Through a series of transactions, the BLM acquired 736 acres of public land surrounding Blue Creek Bay on Lake Coeur d'Alene over a 10-year period. The acquisition generated considerable public interest and required a substantial investment of public funds. The parcels were acquired with the intent of providing public access to the lake while retaining many of the natural elements in close proximity to a rapidly growing urban/suburban area. The key issues are public health and safety and long-term management of a public access site on Lake Coeur d'Alene.

In developing a recreation plan for this area, BLM conducted extensive public outreach in 2007 and 2008 and analyzed alternative levels of development and different management strategies for the area. The plan considered the physical location and characteristics of the area, the natural resource values, recreational opportunities and public input. The Blue Creek Bay Recreation Project Plan, completed in January 2009, identified a modest level of development that included day-use only waterfront facilities, such as a parking area, docks, vault toilet and picnic sites, an upland trailhead and non-motorized trails; and interpretive displays for environmental education. The recreation plan also identified supplementary rules necessary for the safety of the adjacent landowners, public land users, and other visitors to the area.

III. Discussion of Proposed Supplementary Rules

The proposed supplementary rules would implement decisions from the Blue Creek Bay Recreation Project Plan, approved January 7, 2009. The rules are necessary to protect natural resources on public land and provide for the public's health and safety. These supplementary rules would replace five existing restrictions orders and include one new restriction on overnight boat moorage.

The following proposed supplementary rules would implement related decisions from the Blue Creek Bay Recreation Project Plan. Additional background information and justification are included following each proposed rule.

(1) You must not occupy or use the Blue Creek Bay public lands from one hour after sundown to one hour before sunrise.

The subject public lands, easily accessible from and in close proximity to a growing urban center, have attracted a variety of nuisance activities involving local youths, day laborers and drug users; that are incompatible with legitimate uses of the area. Unauthorized uses have included underage drinking parties and illegal drug use, illegal campfires, littering, and vandalism. Many of these activities occur when BLM personnel are not available for patrols or public contact. Numerous complaints have been received from local residents regarding nighttime activities and disturbances, particularly at the log landing area.

The emergency overnight occupancy and use restriction, implemented in April 2008, proved effective in reducing these unauthorized uses of the area. The overnight occupancy and use restriction has provided an additional resource protection tool for BLM Law Enforcement Rangers as well as local law enforcement agencies.

(2) You must not moor any boat overnight on any BLM-managed structure or shoreline.

Local residents strongly objected to overnight use of the subject public lands throughout the planning process. The project plan for this area allows for day-use only, including the proposed boat

docks. This rule would clarify that all forms of overnight occupancy and use are prohibited, including moorage at structures in the area. The overnight occupancy and use restriction, in place since April 2008, effectively eliminated overnight moorage and the supplementary rule would continue this restriction.

When the Kootenai County Waterways Board considered the placement of overnight mooring buoys in Blue Creek Bay, the proposal was rejected due to public objections. Although BLM does not manage the lake bottom, rejection of the county's buoy proposal indicates strong public desire for no overnight occupancy in the Blue Creek Bay area.

(3) You must not start or maintain any open campfires, except when the campfire is completely contained within permanently installed steel fire grates or cooking grills.

This supplementary rule would replace an existing fire restriction order that has been in place for several years in this area. Fires have been a continuous problem as some people have constructed huge bonfires from wooden pallets, freshly (and illegally) collected firewood, beer cans and bottles, and various other forms of toxic and non-toxic refuse. Hundreds of nails and remnants from the burned pallets remained in the parking area and resulted in punctured vehicle tires. This proposed rule is also intended to reduce the risk of wildfire in the area, a concern raised by neighboring private landowners and other members of the public during the planning process.

(4) You must not possess a loaded firearm, except that:

A. You may possess firearms legally within a motor vehicle in accordance with Idaho State Code.

B. Waterfowl hunters may transport unloaded shotguns by the most direct route from either the Yellowstone Road or the Landing Road to the mud flat area for the purpose of hunting waterfowl below the high water mark of Lake Coeur d'Alene within Blue Creek Bay.

The proximity of the site to neighboring homes and the fact that the property is entirely surrounded by private land makes firearm use an inherently hazardous situation. The public land area, comprising 736 acres, is not large enough to safely support hunting with firearms and the likelihood of bullets straying onto private land is quite high. As recreation facilities are constructed and public use of the area increases, the concerns for human health and safety also increase and there will be a need to protect the public investment from vandalism by use of firearms. Replacing the existing firearm restriction with this proposed supplementary rule is in the best interest of public safety and protection of future recreation facilities for the public.

The provision for legal waterfowl hunting on lands managed by the Idaho Department of Lands (IDL) is intended to allow this legitimate use to continue on State land accessible only by crossing BLM lands.

(5) You must not use motor vehicles off county roads.

The area's configuration, small size, topography and existing trail conditions make the area impractical for use by off-highway vehicles (OHVs). The area is designated as a limited use area in the 2007 Coeur d'Alene RMP, and the project plan allows no OHV use on trails that will be developed. Because the BLM acquired this area for management and retention of its natural values, OHV use would not be compatible with the trail improvements in this area. The proposed rule will help ensure the public clearly understands the non-motorized nature of the area.

(6) You must not cut or collect firewood.

Firewood cutting restrictions have been in place for several years as the BLM manages the timber and other resources in the area. Due to the area's accessibility and proximity to a large urban/suburban population center, it would be an attractive area for firewood collection by local residents. If firewood cutting and collecting were allowed, areas along the main roads would receive heavy use which would change the character of the forest in those areas. Firewood cutting and collecting is also incompatible with the variety of recreation uses that will be promoted at the site over the next several years.

The supplementary rules are proposed under the authority of the Federal Land Policy and Management Act (FLPMA), 43 U.S.C. 1740 and its implementing regulations at 43 CFR 8365.1–6. This notice, with detailed maps, will be posted at the Coeur d'Alene Field Office. If adopted, all supplementary rules would be clearly posted on the area's kiosks, in addition to perimeter and trail signage typical of recreation sites.

The proposed supplementary rules would implement a recreation plan that has been available for public comment. In these circumstances, a comment period of 30 days provides adequate opportunity for meaningful analysis, and reasonable time within which to formulate comments for submission.

IV. Procedural Matters

Executive Order 12866, Regulatory Planning and Review

These proposed supplementary rules are not a significant regulatory action and are not subject to review by Office of Management and Budget under Executive Order 12866. These proposed supplementary rules will not have an effect of $100 million or more on the economy. They will not adversely affect in a material way the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities. These proposed supplementary rules will not create a serious inconsistency or otherwise interfere with an action taken or planned by another agency. These proposed supplementary rules do not alter the budgetary effects of entitlements, grants, user fees, or loan programs or the rights or obligations of their recipients; nor do they raise novel legal or policy issues. They merely impose limitations on certain recreational activities on certain public lands to protect natural resources and human health and safety.

Clarity of the Supplementary Rules

Executive Order 12866 requires each agency to write regulations that are simple and easy to understand. The BLM invites your comments on how to make these proposed supplementary rules easier to understand, including answers to questions such as the following:

(1) Are the requirements in the proposed supplementary rules clearly stated?

(2) Do the proposed supplementary rules contain technical language or jargon that interferes with their clarity?

(3) Is the description of the proposed supplementary rules in the ''Discussion of Supplementary Rules'' section of this preamble helpful to your understanding of the proposed supplementary rules? How could this description be more helpful in making the proposed supplementary rules easier to understand?

Please send any comments you have on the clarity of the supplementary rules to the address specified in the **ADDRESSES** section.

National Environmental Policy Act

As documented in Environmental Assessment ID–410–2008–EA–60 for Blue Creek Bay Recreation Project Plan and the associated Finding of No Significant Impact and Decision Record, the proposed supplementary rules do not constitute a major Federal action

significantly affecting the quality of the human environment under section 102(2)(C) of the National Environmental Policy Act of 1969 (NEPA), 42 U.S.C. 4332(2)(C).

Regulatory Flexibility Act

Congress enacted the Regulatory Flexibility Act of 1980 (RFA), as amended, 5 U.S.C. 601–612, to ensure that government regulations do not unnecessarily or disproportionately burden small entities. The RFA requires a regulatory flexibility analysis if a rule would have a significant economic impact, either detrimental or beneficial, on a substantial number of small entities. These proposed supplementary rules should have no effect on business entities of whatever size. They merely would impose reasonable restrictions on certain recreational activities on certain public lands to protect natural resources and public facilities, and human health and safety. Therefore, BLM has determined under the RFA that these proposed supplementary rules would not have a significant economic impact on a substantial number of small entities.

Small Business Regulatory Enforcement Fairness Act

These proposed supplementary rules are not a ''major rule'' as defined at 5 U.S.C. 804(2). They would not result in an effect on the economy of $100 million or more, in an increase in costs or prices, or in significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic and export markets. They would merely impose reasonable restrictions on certain recreational activities on certain public lands to protect natural resources and the environment, and human health and safety.

Unfunded Mandates Reform Act

These proposed supplementary rules do not impose an unfunded mandate on state, local or tribal governments or the private sector of more than $100 million per year; nor do these proposed supplementary rules have a significant or unique effect on State, local, or tribal governments or the private sector. They would merely impose reasonable restrictions on certain recreational activities on certain public lands to protect natural resources and public facilities, and human health and safety. Therefore, BLM is not required to prepare a statement containing the information required by the Unfunded Mandates Reform Act (2 U.S.C. 1531 *et seq.*)

Executive Order 12630, Governmental Actions and Interference With Constitutionally Protected Property Rights (Takings)

The proposed supplementary rules are not a government action capable of interfering with constitutionally protected property rights. The proposed supplementary rules do not address property rights in any form, and do not cause the impairment of anybody's property rights. Therefore, the BLM has determined that these proposed supplementary rules would not cause a taking of private property or require further discussion of takings implications under this Executive Order.

Executive Order 13132, Federalism

The proposed supplementary rules will not have a substantial direct effect on the states, on the relationship between the National Government and the States, or on the distribution of power and responsibilities among the various levels of government. Government vehicles are expressly excluded from the effect of the vehicle restrictions. The firearm restrictions in the supplementary rules do not apply to waterfowl hunting with a valid state hunting license on lands below the ordinary high-water mark of Lake Coeur d'Alene; these lands are managed by the Idaho Department of Lands. Therefore, in accordance with Executive Order 13132, BLM has determined that the proposed supplementary rules do not have sufficient federalism implications to warrant preparation of a Federalism Assessment.

Executive Order 12988, Civil Justice Reform

Under Executive Order 12988, the BLM has determined that these proposed supplementary rules would not unduly burden the judicial system and that the requirements of sections 3(a) and 3(b)(2) of the Order are met. The supplementary rules contain rules of conduct for recreational use of certain public lands to protect human health and the environment.

Executive Order 13175, Consultation and Coordination With Indian Tribal Governments

In accordance with Executive Order 13175, the BLM has found that these proposed supplementary rules do not include policies that have tribal implications. The proposed supplementary rules do not affect lands held for the benefit of Indians, Aleuts, or Eskimos.

Paperwork Reduction Act

These proposed supplementary rules do not directly provide for any information collection that the Office of Management and Budget must approve under the Paperwork Reduction Act, 44 U.S.C. 3501 *et seq.* Any information collection that may result from Federal criminal investigations or prosecutions conducted in enforcing these proposed supplementary rules is exempt from the provisions of the Paperwork Reduction Act of 1995, 44 U.S.C. 3518(c)(1).

Executive Order 13211, Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use

These proposed supplementary rules do not comprise a significant energy action. The supplementary rules would not have an adverse effect on energy supplies, production, or consumption. They only address actions within a recreation area on BLM land and have no connection with energy policy. The restrictions on vehicle use should have no substantial effect on fuel consumption, and no other provision in the supplementary rules has any relationship to energy supply, distribution, or use.

Author

The principal author of these supplementary rules is Brian White, Outdoor Recreation Planner, Coeur d'Alene Field Office, Bureau of Land Management.

For the reasons stated previously, and under the authority for supplementary rules at 43 U.S.C. 1740 and 43 CFR 8365.1–6, the Idaho State Director, Bureau of Land Management, proposes to issue these supplementary rules for the public lands in the Blue Creek Bay area managed by the BLM Coeur d'Alene Field Office, to read as follows:

Supplementary Rules for the Blue Creek Bay Public Lands Managed by the Coeur d'Alene Field Office, Kootenai County, ID

Supplementary Rules

These supplementary rules apply, except as specifically exempted, to the following described public land, all of which are contiguous lands in Boise Meridian, Kootenai County, Idaho:

T. 50 N., R. 2 W.,
Sec. 31, lots 5 to 8, inclusive, and E½NE¼SW¼.
T. 50 N., R. 3 W.,
Sec. 26, portion of SW¼ lying south and west of Sunnyside Road;

Sec. 35, portions of lots 1, 2, and 7, lots 4, 5, and 6, W½NE¼, and N½NW¼.
T. 49 N., R. 2 W.,
Sec. 6, lot 4.
T. 49 N., R. 3 W.,
Sec. 1, portions of lots 1, 2, 5, and 6.

1. You must not occupy or use the Blue Creek Bay public lands from one hour after sundown to one hour before sunrise.

2. You must not moor any boat overnight on any BLM-managed structure or shoreline.

3. You must not start or maintain any open campfires, except when they are completely contained within permanently installed steel fire grates or cooking grills.

4. You must not possess a loaded firearm, except that:

A. You may possess a firearm legally within a motor vehicle in accordance with Idaho State Code.

B. Waterfowl hunters may transport unloaded shotguns by the most direct route from either the Yellowstone Road or the Landing Road to the mud flat area for the purpose of hunting waterfowl below the high water mark of Lake Coeur d'Alene within Blue Creek Bay.

5. You must not use motor vehicles off county roads.

6. You must not cut or collect firewood.

Exceptions

These supplementary rules do not apply to emergency, law enforcement, and Federal or other government entities while conducting official or emergency duties. Motor vehicle restrictions likewise do not apply to emergency, law enforcement, and Federal or other government motor vehicles while conducting official or emergency duties. Exemptions to these supplementary rules may be granted on a case-by-case basis as deemed appropriate by the Authorized Officer.

The prohibition of firearm possession in rule 4 has no effect on hunting by licensed hunters in legitimate pursuit of waterfowl on lands managed by Idaho Department of Lands during the proper season with appropriate firearms.

Enforcement

Any person who violates any of these supplementary rules may be tried before a United States Magistrate and fined no more than $1,000, or imprisoned for no more than 12 months, or both. 43 U.S.C. 1733(a); 43 CFR 8360.0–7; 43 CFR 2932.57(b). Such violations may also be subject to the enhanced fines provided for by 18 U.S.C. 3571. In accordance with 43 CFR 8365.1–7, State or local officials may also impose penalties for violations of Idaho law.

Peter J. Ditton,

Acting Idaho State Director.

[FR Doc. E9–16426 Filed 7–10–09; 8:45 am]

BILLING CODE 4310–GG–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[FBMS Charge Code: LLCAC070000, MU0000]

Notice of Temporary Closure in Mono County, CA

AGENCY: Bureau of Land Management (BLM), Interior.

ACTION: Notice of Temporary Closure.

SUMMARY: Under the authority of 43 CFR 8364.1, notice is hereby given that a segment of a designated road on public land is temporarily closed to all motorized vehicle use and operation, including off-highway vehicles. The purpose of this temporary closure is to prevent the spread of the invasive Quagga Mussel into Crowley Lake. The Quagga Mussel poses a significant threat to the fisheries of the eastern Sierra as well as to hydrologic infrastructures.

DATES: This closure order will be effective upon publication of this notice in the **Federal Register** through October 31, 2009.

ADDRESSES: BLM Bishop Field Office, 351 Pacu Lane, Bishop, CA 93514 (760) 872–5000.

FOR FURTHER INFORMATION CONTACT: Anne Halford, Bureau of Land Management, 351 Pacu Lane Ste. 100, Bishop, CA 93514. Phone: (760) 872–5022.

SUPPLEMENTARY INFORMATION: The temporarily closed road section is 0.47 mile in length from the BLM access point to the Los Angeles Department of Water and Power (LADWP) access point and is described as the designated access point on BLM administered lands in the Long Valley area of Mono County, California in T. 3 S, R. 29 E, NE1/4 of SW1/4 section 27. The access point will be marked with a gate and appropriate signage informing the public about the closure. Closure signs will be posted at the entrance point of closure. Maps of the closure area can be obtained at the BLM Bishop Field Office.

The BLM is implementing this action on a 0.47 mile section of road on public land in Mono County, California. The BLM Bishop Field Office is implementing the closure in coordination with the Los Angeles Department of Water and Power (LADWP) to secure uncontrolled access to Crowley Lake to prevent watercraft that may carry Quagga Mussels from entering the lake.

Discussion of the Order: Under the authority of 43 CFR 8364.1 the BLM will enforce the following rules on public lands within the closed area: No person shall enter the closed area with a motorized vehicle. The following are exempt from this closure: (1) Any Federal, State or local government law enforcement officer or employee engaged in enforcing this closure order or member of an organized rescue or fire fighting force while in the performance of an official duty; and (2) Persons with a permit specifically authorizing the otherwise prohibited act; (3) Any BLM employee, agent, or contractor while in the performance of an official duty, or any person expressly authorized by the BLM.

Penalties: Any person who violates any of these restrictions may be tried before a United States Magistrate and fined no more than $1,000, imprisoned no more than 12 months, or both, in accordance with 43 U.S.C. 1733(a) and 43 CFR 8360.0–7. Such violations may also be subject to the enhanced penalties provided by 18 U.S.C. 3571 and 3581. In accordance with 43 CFR 8365.1–7, State or local officials may also impose penalties for violations of California law.

F. Kirk Halford,

Acting Bishop Field Office Manager.

[FR Doc. E9–16423 Filed 7–10–09; 8:45 am]

BILLING CODE P

INTERNATIONAL TRADE COMMISSION

[Investigation No. 337–TA–644]

In the Matter of Certain Composite Wear Components and Products Containing Same; Notice of Commission Determination Not To Review an Initial Determination Finding Respondents AIAE Engineering Ltd. and Vega Industries in Default and Finding a Violation of Section 337

AGENCY: U.S. International Trade Commission.

ACTION: Notice.

SUMMARY: The United States International Trade Commission hereby provides notice that it has determined not to review an initial determination (''ID'') (Order No. 26) issued by the presiding administrative law judge (''ALJ'') finding respondents AIAE Engineering Limited and Vega

Industries in default and finding a violation of section 337.

FOR FURTHER INFORMATION CONTACT: Paul M. Bartkowski, Office of the General Counsel, U.S. International Trade Commission, 500 E Street, SW., Washington, DC 20436, telephone (202) 708–5432. Copies of non-confidential documents filed in connection with this investigation are or will be available for inspection during official business hours (8:45 a.m. to 5:15 p.m.) in the Office of the Secretary, U.S. International Trade Commission, 500 E Street, SW., Washington, DC 20436, telephone (202) 205–2000. General information concerning the Commission may also be obtained by accessing its Internet server at *http://www.usitc.gov.* The public record for this investigation may be viewed on the Commission's electronic docket (EDIS) at *http://edis.usitc.gov.* Hearing-impaired persons are advised that information on this matter can be obtained by contacting the Commission's TDD terminal on (202) 205–1810.

SUPPLEMENTARY INFORMATION: This investigation was instituted on April 25, 2008, based on a complaint filed by Magotteaux International S/A and Magotteaux, Inc. (collectively, ''Magotteaux''). The complaint, as supplemented, alleged violations of section 337 of the Tariff Act of 1930 (19 U.S.C. **1337) in the importation into the United States, the sale for importation, and the sale within the United States after importation of certain composite wear components and products containing the same that infringe all of the claims of U.S. Patent No. RE 39,998 (''the '998 patent''). The complaint named Fonderie Acciaierie Rioale S.P.A. (''FAR''), AIA Engineering Ltd. (''AIAE''), and Vega Industries (''Vega'') as respondents. FAR was subsequently terminated from the investigation on the basis of a settlement agreement, leaving AIAE and Vega (hereinafter referred to collectively as ''AIAE'') as the remaining respondents.

On May 8, 2009, the ALJ issued the subject ID, granting a motion filed by the Commission investigative attorney (''IA'') for issuance of an initial determination finding AIAE in default and granting in part a motion filed by Magotteaux for issuance of an initial determination finding respondents in default and requesting adverse inferences on importation, infringement, and domestic industry. AIAE filed a petition for review of the ID, which was opposed by the Magotteaux and the IA.

The Commission has determined not to review the subject ID finding AIAE in default pursuant to Rule 210.16(a)(2) and presumes the facts alleged in the complaint to be true with respect to AIAE, in addition to the ALJ's finding of violation pursuant to Rule 210.17. The Commission also determines to waive Commission Rule 210.42(a)(ii), which, unless the Commission orders otherwise, requires that the ALJ issue a recommended determination in conjunction with any initial determination concerning violation of section 337.

In connection with the final disposition of this investigation, the Commission may (1) issue an order that could result in the exclusion of the subject articles from entry into the United States, and/or (2) issue one or more cease-and-desist orders that could result in the respondent being required to cease and desist from engaging in unfair acts in the importation and sale of such articles. Accordingly, the Commission is interested in receiving written submissions that address the form of remedy, if any, that should be ordered. If a party seeks exclusion of an article from entry into the United States for purposes other than entry for consumption, the party should so indicate and provide information establishing that activities involving other types of entry either are adversely affecting it or likely to do so. For background, *see In the Matter of Certain Devices for Connecting Computers via Telephone Lines,* Inv. No. 337–TA–360, USITC Pub. No. 2843 (December 1994) (Commission Opinion).

If the Commission contemplates some form of remedy, it must consider the effects of that remedy upon the public interest. The factors the Commission will consider include the effect that an exclusion order and/or cease-and-desist orders would have on (1) the public health and welfare, (2) competitive conditions in the U.S. economy, (3) U.S. production of articles that are like or directly competitive with those that are subject to investigation, and (4) U.S. consumers. The Commission is therefore interested in receiving written submissions that address the aforementioned public interest factors in the context of this investigation.

If the Commission orders some form of remedy, the U.S. Trade Representative, as delegated by the President, has 60 days to approve or disapprove the Commission's action. *See* Presidential Memorandum of July 21, 2005, 70 FR 43251 (July 26, 2005). During this period, the subject articles would be entitled to enter the United States under bond, in an amount determined by the Commission and prescribed by the Secretary of the Treasury. The Commission is therefore interested in receiving submissions concerning the amount of the bond that should be imposed if a remedy is ordered.

Written Submissions: The parties to the investigation, interested government agencies, and any other interested parties are encouraged to file written submissions on the issues of remedy, the public interest, and bonding. Complainants and the IA are also requested to submit proposed remedial orders for the Commission's consideration. Complainants are also requested to state the dates that the patents expire and the HTSUS numbers under which the accused products are imported. The written submissions and proposed remedial orders must be filed no later than close of business on July 22, 2009. Reply submissions, if any, must be filed no later than the close of business on July 30, 2009. No further submissions on these issues will be permitted unless otherwise ordered by the Commission.

Persons filing written submissions must file the original document and 12 true copies thereof on or before the deadlines stated above with the Office of the Secretary. Any person desiring to submit a document to the Commission in confidence must request confidential treatment unless the information has already been granted such treatment during the proceedings. All such requests should be directed to the Secretary of the Commission and must include a full statement of the reasons why the Commission should grant such treatment. *See* 19 CFR 201.6. Documents for which confidential treatment by the Commission is sought will be treated accordingly. All nonconfidential written submissions will be available for public inspection at the Office of the Secretary.

The authority for the Commission's determination is contained in section 337 of the Tariff Act of 1930, as amended (19 U.S.C. 1337), and in section 210.42 of the Commission's Rules of Practice and Procedure (19 CFR 210.42).

Issued: July 7, 2009.

By order of the Commission.

Marilyn R. Abbott,

Secretary to the Commission.

William R. Bishop,

Acting Secretary to the Commission.

[FR Doc. E9–16407 Filed 7–10–09; 8:45 am]

BILLING CODE P

INTERNATIONAL TRADE COMMISSION

[USITC SE–09–019]

Government in the Sunshine Act Meeting Notice

AGENCY HOLDING THE MEETING: United States International Trade Commission.

TIME AND DATE: July 10, 2009 at 11 a.m.

PLACE: Room 101, 500 E Street, SW., Washington, DC 20436. Telephone: (202) 205–2000.

STATUS: Open to the public.

Matters To Be Considered

1. Agenda for future meetings: none.
2. Minutes.
3. Ratification List.
4. Inv. Nos. 701–TA–464 and 731–TA–1160 (Preliminary) (Prestressed Concrete Steel Wire Strand from China)—briefing and vote. (The Commission is currently scheduled to transmit its determinations to the Secretary of Commerce on or before July 13, 2009; Commissioners' opinions are currently scheduled to be transmitted to the Secretary of Commerce on or before July 20, 2009.)
5. Inv. Nos. 701–TA–465 and 731–TA–1161 (Preliminary) (Certain Steel Grating from China)—briefing and vote. (The Commission is currently scheduled to transmit its determinations to the Secretary of Commerce on or before July 13, 2009; Commissioners' opinions are currently scheduled to be transmitted to the Secretary of Commerce on or before July 20, 2009.)
6. Outstanding action jackets: None.

In accordance with Commission policy, subject matter listed above, not disposed of at the scheduled meeting, may be carried over to the agenda of the following meeting.

Issued: July 1, 2009.

By order of the Commission.

William R. Bishop,

Hearings and Meetings Coordinator.

[FR Doc. E9–16609 Filed 7–9–09; 4:15 pm]

BILLING CODE 7020–02–P

DEPARTMENT OF JUSTICE

Notice of Lodging of Consent Judgment Pursuant to Resource Conservation and Recovery Act

Notice is hereby given that on July 6, 2009, a proposed Consent Judgment in *United States* v. *Citygas Gasoline Corporation, et al.*, Civil Action No. CV–03–6374, was lodged with the United States District Court for the Eastern District of New York.

The proposed Consent Judgment will resolve the United States' claims under Section 9006 of the Resource Recovery and Conservation Act, as amended, 42 U.S.C. 6991e, on behalf of the U.S. Environmental Protection Agency, against the following entities: Citygas Gasoline Corp.; Foster Realty Corp.; 9702–9706 Foster Avenue LLC; Foster Operating Corp.; 10 B. Street Realty Corp.; 10–12 Bond Street, LLC; 4090 Boston Road Corp.; 4090 Boston Road LLC; Connor Gas (N.Y.) Inc.; 4090 N.Y. Corp.; 117–01 Springfield Blvd, LLC; Springfield Operating Corp.; 117–01 N.Y. Corp.; 1081 N.Y. Corp.; Quincy Gas (N.Y.) Inc.; Fulton Gas (N.Y.) Inc.; Flushing 168 Corp.; 1981 N.Y. Corp.; 110–18 Atlantic Avenue, LLC; 73–12 Cooper Avenue, LLC; 168–70 Flushing Avenue, LLC; 100–07 Rockaway Boulevard, LLC; 145–15 Rockaway Boulevard, LLC; 20 Sheridan Boulevard, LLC; 303–309 Tenth Avenue, LLC; 2509 Victory Boulevard, LLC; and Route 295 NJ, LLC (collectively ''Citygas Defendants''). The United States alleges that the Citygas Defendants violated the regulations governing underground storage tanks (''USTs''), set forth at 40 CFR Part 280, at the following twenty-one facilities, which were automobile fueling stations with USTs that defendants have owned and/or operated: (1) 9702 Foster Avenue, Brooklyn, New York; (2) 3715 14th Avenue, Brooklyn, New York; (3) 10 Bond Street, New York, New York; (4) 4090 Boston Road, Bronx, New York; (5) 117–01 Springfield Boulevard, Cambria Heights, New York; (6) 1081 Leggett Avenue, Bronx, New York; (7) 83–10 Astoria Boulevard, Jackson Heights, New York; (8) 1508 Bushwick Avenue, Brooklyn, New York; (9) 2800 Bruckner Boulevard, Bronx, New York; (10) 141–50 Union Turnpike, Flushing, New York; (11) 2642–66 Fulton Street, Brooklyn, New York, (12) 1981 Ocean Avenue, Brooklyn, New York; (13) 94–02 111th Street, Richmond Hill, New York; (14) 65–20 Cooper Avenue, Glendale, New York; (15) 168 Flushing Avenue, Brooklyn, New York; (16) 100–07 Rockaway Boulevard, Ozone Park, New York; (17) 145–15 Rockaway Boulevard, Ozone Park, New York; (18) 20 Sheridan Boulevard, Inwood, New York; (19) 303 10th Avenue, New York, New York; (20) 2509 Victory Boulevard, Staten Island, New York; (21) 185 Straughns Mill Road, Pedrickstown, New Jersey. 3023 Route 23, LLC, which is the owner and/or operator of four USTs at 3023 Route 23, West Milford, New Jersey, is also a signatory to the Consent Judgment.

The Consent Judgment requires the Citygas Defendants to pay a civil penalty of $1,400,000. The Consent Judgment also provides for injunctive relief to be implemented over the next five years at the Citygas Defendants' facilities, consisting of maintenance of ongoing compliance with the UST regulations, and submission of reports demonstrating such compliance.

The Department of Justice will receive, for a period of thirty (30) days from the date of this publication, comments relating to the Consent Judgment. Comments should be addressed to the Assistant Attorney General, Environment and Natural Resources Division, and either e-mailed to *pubcomment-ees.enrd@usdoj.gov* or mailed to P.O. Box 7611, U.S. Department of Justice, Washington, DC 20044–7611, and should refer to *United States* v. *Citygas Gasoline Corporation, et al.*, Civil Action No. CV–03–6374, D.J. Ref. No. 90–7–1–07464.

The proposed Consent Judgment may be examined at the Office of the United States Attorney, Eastern District of New York, 271 Cadman Plaza East, 7th Fl., Brooklyn, New York 11201, and at the United States Environmental Protection Agency, Region II, 290 Broadway, New York, New York 10007–1866. During the public comment period, the proposed Consent Judgment may also be examined on the following Department of Justice Web site, *http://www.usdoj.gov/enrd/Consent_Decrees.html*. A copy of the proposed Consent Judgment may be obtained by mail from the Consent Decree Library, P.O. Box 7611, U.S. Department of Justice, Washington, DC 20044–7611 or by faxing or e-mailing a request to Tonia Fleetwood (*tonia.fleetwood@usdoj.gov*), fax no. (202) 514–0097, phone confirmation number (202) 514–1547. In requesting a copy from the Consent Decree Library, please enclose a check in the amount of $33.75 (25 cents per page reproduction cost) payable to the U.S. Treasury or, if by email or fax, forward a check in that amount to the Consent Decree Library at the stated address.

Maureen Katz,

Assistant Section Chief, Environmental Enforcement Section, Environment and Natural Resources Division.

[FR Doc. E9–16566 Filed 7–10–09; 8:45 am]

BILLING CODE 4410–15–P

DEPARTMENT OF JUSTICE

Notice of Lodging of Proposed Consent Decree Under the Clean Air Act

Notice is hereby given that on June 25, 2009, a proposed Consent Decree (''Decree'') in *United States* v. *Holcim (US) Inc.*, Civil Action No. 2:09–cv–12526–LPZ–DAS, was lodged with the United States District Court for the Eastern District of Michigan.

In this action the United States seeks to address violations of the Clean Air Act at a Portland cement manufacturing facility owned and operated by the Defendant, Holcim (US) Inc., in Dundee, Michigan. The violations, which occurred numerous times for several years, involved emissions from the main stack for two kilns which exceeded 15% opacity and the baghouse inlet temperatures for each kiln exceeding its limitation.

During the course of settlement negotiations with the Department of Justice, the Defendant on November 11, 2008 announced that it must reduce production capacity in its cement operations in response to the extensive downturn in the demand for cement products and stated it would permanently close the Dundee facility. The Defendant permanently shut down its two kilns at the Dundee facility, one kiln on November 30, 2008 and the other kiln on March 14, 2009.

The proposed Decree resolves the Defendant's violations by implementing injunctive relief which will ensure, if operating the kilns at the Dundee facility, the Defendant will not exceed the opacity limitation at the main stack and will not exceed the applicable baghouse inlet temperature for the kilns. Additionally, the Defendant has reporting, notification and approval requirements under the Decree to the U.S. Environmental Protection Agency (''EPA'') and the Michigan Department of Environmental Quality (''MDEQ''), which includes seeking permission and receiving approval from EPA and MDEQ to re-start a permanently closed kiln. The proposed Decree also requires payment of a civil penalty in the amount of $159,607.

The Department of Justice will receive for a period of thirty (30) days from the date of this publication comments relating to the proposed Decree. Comments should be addressed to the Assistant Attorney General, Environment and Natural Resources Division, and either e-mailed to *pubcomment-ees.enrd@usdoj.gov* or mailed to P.O. Box 7611, U.S. Department of Justice, Washington, DC 20044–7611, and should refer to *United States* v. *Holcim (US) Inc.*, D.J. Ref. No. 90–5–2–1–09594.

The proposed Decree may be examined at the Office of the United States Attorney, 211 W. Fort Street, Suite 2001, Detroit, Michigan 48226, and at U.S. EPA Region 5, 77 W. Jackson Blvd., 16th Floor (EPA Library), Chicago, Illinois 60604. During the public comment period, the proposed Decree may also be examined on the following Department of Justice Web site *http://www.usdoj.gov/enrd/Consent_Decrees.html*. A copy of the proposed Decree may also be obtained by mail from the Consent Decree Library, P.O. Box 7611, U.S. Department of Justice, Washington, DC 20044–7611 or by faxing or e-mailing a request to Tonia Fleetwood (*tonia.fleetwood@usdoj.gov*), fax no. (202) 514–0097, phone confirmation number (202) 514–1547. In requesting a copy from the Consent Decree Library, please enclose a check in the amount of $11.00 (25 cents per page reproduction cost) payable to the U.S. Treasury or, if by e-mail or fax, forward a check in that amount to the Consent Decree Library at the stated address.

Maureen Katz,

Assistant Chief Environmental Enforcement Section, Environment and Natural Resources Division.

[FR Doc. E9–16412 Filed 7–10–09; 8:45 am]

BILLING CODE 4410–15–P

DEPARTMENT OF JUSTICE

Bureau of Alcohol, Tobacco, Firearms and Explosives

[Docket No. ATF 32N; ATF O 1120.8]

Delegation Order—Authority To Facilitate Implementation of the NICS Improvement Amendments Act of 2007

1. *Purpose.* This order delegates the authority to exercise the authorities and responsibilities committed to the Director of the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) under the NICS Improvement Amendments Act of 2007, Public Law 110–180 (NIAA). This authority is to establish and enforce the criteria that applicable Federal departments and agencies and states use to create qualifying relief from firearms disabilities programs, to make decisions as to whether applicable Federal departments and agencies and states have properly implemented and certified relief from firearms disabilities programs under the NIAA, and to make any related determinations under the NIAA regarding such relief from firearms disabilities programs.

2. *Delegations.* Under the authority vested in the Director, Bureau of Alcohol, Tobacco, Firearms and Explosives, by Title 28 U.S.C. 599A, 28 CFR 0.130–0.133, and Attorney General Order Number 3072–2009, Delegation of Authority to the Director of the Bureau of Alcohol, Tobacco, Firearms, and Explosives to Facilitate Implementation of the NICS Improvement Amendments of 2007, I hereby delegate to the Assistant Director, Enforcement Programs and Services, the authority to exercise the authorities and responsibilities committed to the Director of ATF under the NIAA. This authority is to establish and enforce the criteria that applicable Federal departments and agencies and states use to create qualifying relief from firearms disabilities programs, to make decisions as to whether applicable Federal departments and agencies and states have properly implemented and certified relief from firearms disabilities programs under the NIAA, and to make any related determinations under the NIAA regarding such relief from firearms disabilities programs.

3. *Redelegation.* The authority in this order may be redelegated to a position not lower than the Chief, Firearms Programs Division.

4. *Questions.* Questions regarding this order should be addressed to the Chief, Firearms Programs Division at (202) 648–7090.

Signed: June 22, 2009.

Kenneth Melson,

Acting Director.

[FR Doc. E9–16453 Filed 7–10–09; 8:45 am]

BILLING CODE 4410–FY–P

DEPARTMENT OF JUSTICE

Drug Enforcement Administration

Importer of Controlled Substances; Notice of Application

Pursuant to 21 U.S.C. 958(i), the Attorney General shall, prior to issuing a registration under this Section to a bulk manufacturer of a controlled substance in schedule I or II, and prior to issuing a regulation under 21 U.S.C. 952(a)(2) authorizing the importation of such a substance, provide manufacturers holding registrations for the bulk manufacture of the substance an opportunity for a hearing.

Therefore, in accordance with Title 21, Code of Federal Regulations (CFR), 1301.34(a), this is notice that on June 16, 2009, Noramco, Inc., Division of Ortho-McNeil, Inc., 500 Swedes

Landing Road, Wilmington, Delaware 19801, made application by letter to the Drug Enforcement Administration (DEA) to be registered as an importer of Thebaine (9333), a basic class of controlled substance listed in schedule II.

The company plans to import a Thebaine derivative for the bulk manufacture of controlled substances for their customers. The company will also import analytical reference standards for distribution to their customers for research purposes.

Any bulk manufacturer who is presently, or is applying to be, registered with DEA to manufacture such basic class of controlled substance may file comments or objections to the issuance of the proposed registration and may, at the same time, file a written request for a hearing on such application pursuant to 21 CFR 1301.43 and in such form as prescribed by 21 CFR 1316.47.

Any such comments or objections being should be addressed, in quintuplicate, to the Drug Enforcement Administration, Office of Diversion Control, Federal Register Representative (ODL), 8701 Morrissette Drive, Springfield, VA 22152; and must be filed no later than August 12, 2009.

This procedure is to be conducted simultaneously with, and independent of, the procedures described in 21 CFR 1301.34(b), (c), (d), (e), and (f). As noted in a previous notice published in the **Federal Register** on September 23, 1975, 40 FR 43745–46), all applicants for registration to import a basic class of any controlled substances in schedule I or II are, and will continue to be, required to demonstrate to the Deputy Assistant Administrator, Office of Diversion Control, Drug Enforcement Administration, that the requirements for such registration pursuant to 21 U.S.C. 958(a); 21 U.S.C. 823(a); and 21 CFR 1301.34(b), (c), (d), (e), and (f) are satisfied.

Dated: July 1, 2009.

Joseph T. Rannazzisi,

Deputy Assistant Administrator, Office of Diversion Control, Drug Enforcement Administration.

[FR Doc. E9–16520 Filed 7–10–09; 8:45 am]

BILLING CODE 4410–09–P

DEPARTMENT OF JUSTICE

Drug Enforcement Administration

Manufacturer of Controlled Substances; Notice of Application

Pursuant to § 1301.33(a) of Title 21 of the Code of Federal Regulations (CFR), this is notice that on May 20, 2009, Organix Inc., 240 Salem Street, Woburn, Massachusetts 01801, made application by letter to the Drug Enforcement Administration (DEA) to be registered as a bulk manufacturer of Marihuana (7360), a basic class of controlled substance listed in schedule I.

The company plans to manufacture a synthetic cannabinol in bulk for sale to its customers for research purposes. No other activity for this drug code is authorized for this registration.

Any other such applicant, and any person who is presently registered with DEA to manufacture such substances, may file comments or objections to the issuance of the proposed registration pursuant to 21 CFR 1301.33(a).

Any such written comments or objections should be addressed, in quintuplicate, to the Drug Enforcement Administration, Office of Diversion Control, Federal Register Representative (ODL), 8701 Morrissette Drive, Springfield, Virginia 22152; and must be filed no later than September 11, 2009.

Dated: July 1, 2009.

Joseph T. Rannazzisi,

Deputy Assistant Administrator, Office of Diversion Control, Drug Enforcement Administration.

[FR Doc. E9–16521 Filed 7–10–09; 8:45 am]

BILLING CODE 4410–09–P

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[Notice (09–066)]

Review of U.S. Human Space Flight Plans Committee; Meeting

AGENCY: National Aeronautics and Space Administration.

ACTION: Notice of meeting.

SUMMARY: In accordance with the Federal Advisory Committee Act, Public Law 92–463, as amended, the National Aeronautics and Space Administration announces a meeting of the Review of U.S. Human Space Flight Plans Committee. The agenda topics for the meeting include:

- Kennedy Space Center Perspective.
- Constellation projects.
- Committee subgroup report.
- Public comment.

DATES: Thursday, July 30, 2009, 8 a.m.–4 p.m. **Note:** All times listed are local times.

ADDRESSES: Hilton Cocoa Beach Oceanfront, Grand Ballroom, 1550 North Atlantic Avenue, Cocoa Beach, Florida 32931, 321–799–0003.

FOR FURTHER INFORMATION CONTACT: Mr. Philip R. McAlister, Office of Program Analysis and Evaluation, National Aeronautics and Space Administration, Washington, DC 20546. Phone 202–358–0712.

SUPPLEMENTARY INFORMATION: The meeting will be open to the public up to the seating capacity of the room. It is imperative that the meeting be held on this date to accommodate the scheduling priorities of the key participants.

P. Diane Rausch,

Advisory Committee Management Officer, National Aeronautics and Space Administration.

[FR Doc. E9–16533 Filed 7–10–09; 8:45 am]

BILLING CODE P

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[Notice (09–064)]

Review of U.S. Human Space Flight Plans Committee; Meeting

AGENCY: National Aeronautics and Space Administration.

ACTION: Notice of meeting.

SUMMARY: In accordance with the Federal Advisory Committee Act, Public Law 92–463, as amended, the National Aeronautics and Space Administration announces a meeting of the Review of U.S. Human Space Flight Plans Committee. The agenda topics for the meeting include:

- Johnson Space Center Perspective.
- Constellation projects.
- Committee subgroup report.
- Public comment.

DATES: Tuesday, July 28, 2009, 10 a.m.–4 p.m. **Note:** All times listed are local times.

ADDRESSES: South Shore Harbour Resort & Conference Center, Crystal Ballroom Salon A & B, 2500 South Shore Blvd., League City, TX 77573, 800–442–5005.

FOR FURTHER INFORMATION CONTACT: Mr. Philip R. McAlister, Office of Program Analysis and Evaluation, National Aeronautics and Space Administration, Washington, DC 20546. Phone 202–358–0712.

SUPPLEMENTARY INFORMATION: The meeting will be open to the public up to the seating capacity of the room. It is imperative that the meeting be held on this date to accommodate the

scheduling priorities of the key participants.

P. Diane Rausch,

Advisory Committee Management Officer, National Aeronautics and Space Administration.

[FR Doc. E9–16552 Filed 7–10–09; 8:45 am]

BILLING CODE P

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[Notice (09–065)]

Review of U.S. Human Space Flight Plans Committee; Meeting

AGENCY: National Aeronautics and Space Administration.

ACTION: Notice of meeting.

SUMMARY: In accordance with the Federal Advisory Committee Act, Public Law 92–463, as amended, the National Aeronautics and Space Administration announces a meeting of the Review of U.S. Human Space Flight Plans Committee. The agenda topics for the meeting include:

- Marshall Space Flight Center Perspective.
- Constellation projects.
- Committee subgroup reports.
- Public comment.

DATES: Wednesday, July 29, 2009, 8 a.m.–4 p.m. **Note:** All times listed are local times.

ADDRESSES: The Davidson Center for Space Exploration, The U.S. Space & Rocket Center, One Tranquility Base, Huntsville, AL 35805, 256–837–3400.

FOR FURTHER INFORMATION CONTACT: Mr. Philip R. McAlister, Office of Program Analysis and Evaluation, National Aeronautics and Space Administration, Washington, DC 20546. Phone 202–358–0712.

SUPPLEMENTARY INFORMATION: The meeting will be open to the public up to the seating capacity of the room. It is imperative that the meeting be held on this date to accommodate the scheduling priorities of the key participants.

P. Diane Rausch,

Advisory Committee Management Officer, National Aeronautics and Space Administration.

[FR Doc. E9–16551 Filed 7–10–09; 8:45 am]

BILLING CODE P

NATIONAL CREDIT UNION ADMINISTRATION

Sunshine Act; Notice of Agency Meeting

TIME AND DATE: 10 a.m., Thursday, July 16, 2009.

PLACE: Board Room, 7th Floor, Room 7047, 1775 Duke Street, Alexandria, VA 22314–3428.

STATUS: Open.

MATTERS TO BE CONSIDERED:

1. Proposed Rule—Parts 701 and 741 of NCUA's Rules and Regulations, National Credit Union Share Insurance Fund Premium and One Percent Deposit.
2. Final Rule—Parts 741, 748 and 749 of NCUA's Rules and Regulations, Credit Union Reporting.
3. Final Rule—Part 707 of NCUA's Rules and Regulations, Truth in Savings Act Disclosures.
4. Interest Rate Ceiling Determination under Section 107(5) of the Federal Credit Union Act.
5. Reprogramming of NCUA's Operating Budget for 2009.
6. Insurance Fund Report.

RECESS: 11 a.m.

TIME AND DATE: 11:15 a.m., Thursday, July 16, 2009.

PLACE: Board Room, 7th Floor, Room 7047, 1775 Duke Street, Alexandria, VA 22314–3428.

STATUS: Closed.

MATTERS TO BE CONSIDERED:

1. Insurance Appeal. Closed pursuant to Exemption (6).
2. Part 703 of NCUA's Rules and Regulations, Pilot Program Request, Closed pursuant to Exemption (8).
3. Consideration of Supervisory Activities (7). Closed pursuant to some or all of the following: Exemptions (8) and (9)(A)(ii) and 9(B).

FOR FURTHER INFORMATION CONTACT: Mary Rupp, Secretary of the Board, Telephone: 703–518–6304.

Mary Rupp,

Board Secretary.

[FR Doc. E9–16687 Filed 7–9–09; 4:15 pm]

BILLING CODE 7535–01–P

NATIONAL SCIENCE FOUNDATION

Committee Management; Notice of Establishment

The Director of the National Science Foundation has determined that the establishment of the Proposal Review Panel for Emerging Frontiers in Biological Sciences necessary and in the public interest in connection with the performance of duties imposed upon the National Science Foundation (NSF), by 42 U.S.C. 1861 *et seq*. This determination follows consultation with the Committee Management Secretariat, General Services Administration.

Name of Committee: Proposal Review Panel for Emerging Frontiers in Biological Sciences (#44011).

Purpose: To advise the National Science Foundation on the merit of proposals requesting financial support for research and research-related activities under the purview of the Office of Emerging Frontiers located in the Directorate of Biological Sciences.

Responsible NSF Official: William Zamer, Office Director, Emerging Frontiers, Directorate for Biological Sciences, National Science Foundation, 4201 Wilson Boulevard, Arlington, VA 22230. Telephone: 703/292–8400.

Dated: July 8, 2009.

Susanne Bolton,

Committee Management Officer.

[FR Doc. E9–16454 Filed 7–10–09; 8:45 am]

BILLING CODE 7555–01–P

NUCLEAR REGULATORY COMMISSION

[NRC–2009–0308]

Draft Regulatory Guide: issuance, availability

AGENCY: Nuclear Regulatory Commission.

ACTION: Notice of issuance and availability of Draft Regulatory Guide, DG–1215.

FOR FURTHER INFORMATION CONTACT: Paul Prescott, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001, telephone: (301) 415–3026, e-mail: *Paul.Prescott@nrc.gov* or, R.A. Jervey, telephone (301) 251–7404, e-mail: *raj@nrc.gov.*

SUPPLEMENTARY INFORMATION:

I. Introduction

The U.S. Nuclear Regulatory Commission (NRC) is issuing for public comment a draft guide in the agency's ''Regulatory Guide'' series. This series was developed to describe and make available to the public such information as methods that are acceptable to the NRC staff for implementing specific parts of the NRC's regulations, techniques that the staff uses in evaluating specific problems or postulated accidents, and data that the staff needs in its review of applications for permits and licenses.

The draft regulatory guide (DG), titled, ''Quality Assurance Program

Requirements (Design and Construction),'' is temporarily identified by its task number, DG–1215, which should be mentioned in all related correspondence. DG–1215 is proposed Revision 4 of Regulatory Guide 1.28.

DG–1215 describes methods that the NRC staff considers acceptable for complying with the provisions of Appendix B, ''Quality Assurance Criteria for Nuclear Power Plants and Fuel Reprocessing Plants,'' to Title 10, part 50, ''Domestic Licensing of Production and Utilization Facilities,'' of the Code of Federal Regulations (10 CFR part 50) for establishing and implementing a quality assurance (QA) program for the design and construction of nuclear power plants, fuel fabrication plants and fuel reprocessing plants.

The methods described in this revision are similar to the methods described in Regulatory Guide (RG) 1.28, ''Quality Assurance Program Requirements (Design and Construction),'' Revision 3, which is the previously published version of this regulatory guide. RG 1.33, ''Quality Assurance Program Requirements (Operation)'' addresses additional guidance for the establishment and execution of QA programs for nuclear power plants during the operations phase, which is unaffected by the revision to RG 1.28. DG–1215 endorses methods defined in American Society of Mechanical Engineers (ASME) NQA–1, ''Quality Assurance Requirements for Nuclear Facility Applications.'' The NRC is aware that the ASME standards committee has proposed minor changes to NQA–1 in a draft of ASME NQA–1a–2009, Addenda to ASME NQA–1–2008. If these addenda are issued in a timely manner, they will be considered for endorsement in RG 1.28, revision 4.

II. Further Information

The NRC staff is soliciting comments on DG–1215. Comments may be accompanied by relevant information or supporting data and should mention DG–1215 in the subject line. Comments submitted in writing or in electronic form will be made available to the public in their entirety through the NRC's Agencywide Documents Access and Management System (ADAMS).

Personal information will not be removed from your comments. You may submit comments by any of the following methods:

1. *Mail comments to:* Rulemaking and Directives Branch, Office of Administration, MS TWB–05–B01M, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001.

2. *Federal e-Rulemaking Portal:* Go to *http://www.regulations.gov* and search for documents filed under Docket ID [NRC–2009–0308]. Address questions about NRC dockets to Carol Gallagher, 301–492–3668; e-mail *Carol.Gallagher@nrc.gov*.

3. *Fax comments to:* Rulemaking and Directives Branch, Office of Administration, U.S. Nuclear Regulatory Commission at (301) 492–3446.

Requests for technical information about DG–1215 may be directed to the NRC contact, Paul Prescott at (301) 415–3026 or e-mail to *Paul.Prescott@nrc.gov*.

Comments would be most helpful if received by September 8, 2009. Comments received after that date will be considered if it is practical to do so, but the NRC is able to ensure consideration only for comments received on or before this date. Although a time limit is given, comments and suggestions in connection with items for inclusion in guides currently being developed or improvements in all published guides are encouraged at any time.

Electronic copies of DG–1215 are available through the NRC's public Web site under Draft Regulatory Guides in the ''Regulatory Guides'' collection of the NRC's Electronic Reading Room at *http://www.nrc.gov/reading-rm/doc-collections/*. Electronic copies are also available in ADAMS (*http://www.nrc.gov/reading-rm/adams.html*), under Accession No. ML090150402.

In addition, regulatory guides are available for inspection at the NRC's Public Document Room (PDR), which is located at 11555 Rockville Pike, Rockville, Maryland. The PDR's mailing address is USNRC PDR, Washington, DC 20555–0001. The PDR can also be reached by telephone at (301) 415–4737 or (800) 397–4205, by fax at (301) 415–3548, and by e-mail to *pdr.resource@nrc.gov*.

Regulatory guides are not copyrighted, and Commission approval is not required to reproduce them.

Dated at Rockville, Maryland, this 6th day of July 2009.

For the Nuclear Regulatory Commission.

Mark P. Orr,

Acting Chief, Regulatory Guide Development Branch, Division of Engineering, Office of Nuclear Regulatory Research.

[FR Doc. E9–16494 Filed 7–10–09; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

[NRC–2008–0147]

License Renewal Interim Staff Guidance LR–ISG–2008–01: Staff Guidance Regarding the Station Blackout Rule (10 CFR 50.63) Associated With License Renewal Applications; Notice of Withdrawal

AGENCY: Nuclear Regulatory Commission (NRC).

ACTION: Notice of withdrawal.

SUMMARY: The NRC is withdrawing its proposed License Renewal Interim Staff Guidance (LR–ISG) LR–ISG–2008–01, ''Staff Guidance Regarding the Station Blackout Rule (10 CFR 50.63) Associated with License Renewal Applications.'' The NRC staff issued the proposed guidance to clarify the acceptance criteria for the scoping of systems, structures, and components in accordance with section 54.4(a)(3) of Title 10 of the Code of Federal Regulations (10 CFR 54.4(a)(3)). However, after evaluating comments received on the proposed guidance, the NRC staff has determined that the current acceptance criteria, as provided in section 2.5.2.1.1 of NUREG–1800, Revision 1, ''Standard Review Plan for Review of License Renewal Applications for Nuclear Power Plants'' (SRP–LR), are adequate for the NRC staff's review of license renewal applications. As such, the NRC staff is withdrawing the proposed LR–ISG–2008–01.

On March 12, 2008, the NRC requested public comments on the proposed LR–ISG in the **Federal Register** (73 FR 13258). The proposed LR–ISG and accompanying figures are available in the NRC's Agencywide Documents Access and Management System (ADAMS) under Accession Nos. ML080520619 and ML080520620, respectively.

The NRC staff drafted the proposed LR–ISG–2008–01 after finding that some license renewal applications did not include within the scope of license renewal all structures and components required by 10 CFR 54.4(a)(3) for demonstrating compliance with 10 CFR 50.63 (Station Blackout Rule). The proposed LR–ISG was intended to clarify the NRC staff's acceptance criteria in SRP–LR section 2.5.2.1.1, ''Components Within the Scope of SBO (10 CFR 50.63).''

By letters dated May 9, 2008 (ML081400346), and May 12, 2008 (ML081350619), the NRC received comments on the proposed LR–ISG from the Strategic Teaming and Resource

Sharing alliance and the Nuclear Energy Institute (NEI), respectively. On July 18, 2008, the NRC staff discussed these comments during a public meeting with NEI and industry representatives, as documented in ''Summary of the License Renewal Meeting Held between the U.S. Nuclear Regulatory Commission Staff and the Nuclear Energy Institute,'' dated October 3, 2008 (ML082480547). Overall, the comments indicated that the NRC staff's proposed guidance is too prescriptive and does not acknowledge the unique design aspects of each plant, as reflected in the plant's current licensing basis.

The NRC staff evaluated both the comments submitted in writing, and those provided during the July 18, 2008, meeting and subsequent public license renewal meetings, and determined that the proposed clarification in LR–ISG–2008–01 is unnecessary because the NRC staff's review of license renewal applications is based on the plant-specific current licensing bases, regulatory requirements, and offsite power design configurations. As such, the NRC staff will continue to review license renewal applications against the acceptance criteria in SRP–LR section 2.5.2.1.1 to ensure applicants include within the scope of license renewal the systems, structures, and components that perform functions to demonstrate compliance with the Station Blackout Rule, as required by 10 CFR 54.4(a)(3).

Therefore, by this action, the NRC is withdrawing LR–ISG–2008–01.

ADDRESSES: Documents created or received after November 1, 1999, are available electronically at the NRC's Public Electronic Reading Room on the Internet at *http://www.nrc.gov/reading-rm/adams.html*. From this site, the public can gain entry into ADAMS. If you do not have access to the Internet or if there are any problems in accessing the documents located in ADAMS, contact the NRC Public Document Room reference staff at 1–800–397–4209, 301–415–4737, or by e-mail at *PDR.Resource@nrc.gov*.

FOR FURTHER INFORMATION CONTACT: Mr. Matthew Homiack, Division of License Renewal, Office of Nuclear Reactor Regulation, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001; telephone 301–415–1683; or e-mail *Matthew.Homiack@nrc.gov*.

SUPPLEMENTARY INFORMATION: The NRC issues LR–ISGs to communicate insights and lessons learned, and to address emergent issues not addressed in certain license renewal guidance documents. The NRC staff and stakeholders can use approved LR–ISGs until their guidance is incorporated into a formal license renewal guidance document revision. The NRC posts its issued LR–ISGs on the NRC Public Web page at *http://www.nrc.gov/reading-rm/doc-collections/isg*.

Dated at Rockville, Maryland, this 7th day of July 2009.

For the Nuclear Regulatory Commission.

Brian E. Holian,

Director, Division of License Renewal, Office of Nuclear Reactor Regulation.

[FR Doc. E9–16486 Filed 7–10–09; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

[NRC–2009–0117]

Notice of Revised Regulatory Guide

AGENCY: Nuclear Regulatory Commission.

ACTION: Notice of Revised Regulatory Guide (RG) 1.200, Revision 2, ''An Approach for Determining the Technical Adequacy of Probabilistic Risk Assessment Results for Risk-Informed Activities.''

FOR FURTHER INFORMATION CONTACT: Mary Drouin, Office of Nuclear Regulatory Research, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001, telephone (301) 251–7574 or e-mail to *Mary.Drouin@nrc.gov*.

SUPPLEMENTARY INFORMATION:

I. Introduction

The Nuclear Regulatory Commission (NRC) issued Revision 2 of RG 1.200 on March 17, 2009, which was published in the **Federal Register**, 74 FR 11381. RG 1.200, Revision 2 is a guide in the agency's ''Regulatory Guide'' series. This series was developed to describe and make available to the public information such as methods that are acceptable to the NRC staff for implementing specific parts of the agency's regulations, techniques that the staff uses in evaluating specific problems or postulated accidents, and data that the staff needs in its review of applications for permits and licenses.

A sentence was inadvertently omitted from the draft version that was issued for public comment and the final version that was published in March 2009. The current version of Regulatory Guide 1.200 on the NRC Web site includes the omitted sentence at the end of the first paragraph in Regulatory Position C.1.2.5.

II. Further Information

Electronic copies of Regulatory Guide 1.200, Revision 2 are available through the NRC's public Web site under ''Regulatory Guides'' at *http://www.nrc.gov/reading-rm/doc-collections/*. In addition, regulatory guides are available for inspection at the NRC's Public Document Room (PDR) located at Room O–1F21, One White Flint North, 11555 Rockville Pike, Rockville, Maryland 20852–2738. The PDR's mailing address is USNRC PDR, Washington, DC 20555–0001. The PDR can also be reached by telephone at (301) 415–4737 or (800) 397–4209, by fax at (301) 415–3548, and by e-mail to *pdr.resource@nrc.gov*.

Regulatory guides are not copyrighted, and NRC approval is not required to reproduce them.

Dated at Rockville, Maryland, this 2nd day of July 2009.

For the Nuclear Regulatory Commission.

Mark P. Orr,

Acting Chief, Regulatory Guide Development Branch, Division of Engineering, Office of Nuclear Regulatory Research.

[FR Doc. E9–16499 Filed 7–10–09; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

[Docket Nos. 50–254 and 50–265; NRC–2009–0309]

Exelon Generation Company, LLC; Notice of Withdrawal of Application for Amendment to Facility Operating License

The U.S. Nuclear Regulatory Commission (the Commission) has granted the request of Exelon Generation Company, LLC (the licensee) to withdraw its December 21, 2007, application for proposed amendment to Renewed Facility Operating License Nos. DPR–29 and DPR–30 for the Quad Cities Nuclear Power Station, Units 1 and 2, located in Rock Island County, Illinois.

The proposed amendment would have revised the Technical Specifications Surveillance Requirements to establish an acceptance criterion to verify that total battery connector resistances for the 125 and 250 volt direct current batteries are within pre-established limits that ensure the batteries can perform their design function.

The Commission had previously issued a Notice of Consideration of Issuance of Amendment published in the **Federal Register** on February 26, 2008 (73 FR 10298) and December 30, 2008 (73 FR 79932). However, by letter dated June 25, 2009, the licensee withdrew the proposed change.

For further details with respect to this action, see the application for amendment dated December 21, 2007, and the licensee's letter dated June 25, 2009, which withdrew the application for license amendment. Documents may be examined, and/or copied for a fee, at the NRC's Public Document Room (PDR), located at One White Flint North, Public File Area O1 F21, 11555 Rockville Pike (first floor), Rockville, Maryland. Publicly available records will be accessible electronically from the Agencywide Documents Access and Management System (ADAMS) Public Electronic Reading Room on the Internet at the NRC Web site, *http://www.nrc.gov/reading-rm/adams.html*. Persons who do not have access to ADAMS or who encounter problems in accessing the documents located in ADAMS should contact the NRC PDR Reference staff by telephone at 1–800–397–4209, or 301–415–4737 or by e-mail to *pdr.resource@nrc.gov*.

Dated at Rockville, Maryland, this 7th day of July 2009.

For the Nuclear Regulatory Commission.

Christopher Gratton,

Senior Project Manager, Plant Licensing Branch III–2, Division of Operating Reactor Licensing, Office of Nuclear Reactor Regulation.

[FR Doc. E9–16491 Filed 7–10–09; 8:45 am]

BILLING CODE 7590–01–P

POSTAL REGULATORY COMMISSION

[Docket Nos. MC2009–33 and CP2009–44; Order No. 241]

New Competitive Postal Product

AGENCY: Postal Regulatory Commission.

ACTION: Notice.

SUMMARY: The Commission is noticing a recently-filed Postal Service request to add Express Mail & Priority Mail Contract 8 to the Competitive Product List. The Postal Service has also filed a related contract. This notice addresses procedural steps associated with these filings.

DATES: Comments are due July 15, 2009.

ADDRESSES: Submit comments electronically via the Commission's Filing Online system at *http://www.prc.gov*.

FOR FURTHER INFORMATION CONTACT: Stephen L. Sharfman, General Counsel, 202–789–6820 and *stephen.sharfman@prc.gov*.

SUPPLEMENTARY INFORMATION:

I. Introduction

On July 2, 2009, the Postal Service filed a formal request pursuant to 39 U.S.C. 3642 and 39 CFR 3020.30 *et seq.* to add Express Mail & Priority Mail Contract 8 to the Competitive Product List.[1] On July 6, 2009, the Postal Service filed a revised version of its filing which includes attachments inadvertently omitted from the July 2, 2009 request.[2] The Postal Service asserts that the Express Mail & Priority Mail Contract 8 product is a competitive product ''not of general applicability'' within the meaning of 39 U.S.C. 3632(b)(3). *Id.* at 1. The Request has been assigned Docket No. MC2009–33.

The Postal Service contemporaneously filed a contract related to the proposed new product pursuant to 39 U.S.C. 3632(b)(3) and 39 CFR 3015.5. *Id.* at 2. The contract has been assigned Docket No. CP2009–44.

Request. The Request incorporates (1) A redacted version of the Governors' Decision authorizing the new product; (2) a redacted version of the contract; (3) requested changes to the Mail Classification Schedule product list; (4) a Statement of Supporting Justification as required by 39 CFR 3020.32; and (5) certification of compliance with 39 U.S.C. 3633(a).[3] Substantively, the Request seeks to add Express Mail & Priority Mail Contract 8 to the Competitive Product List. Request at 1–2.

In the Statement of Supporting Justification, Mary Prince Anderson, Manager, Sales and Communications, Expedited Shipping, asserts that the service to be provided under the contract will cover its attributable costs, make a positive contribution to institutional costs, and increase contribution toward the requisite 5.5 percent of the Postal Service's total institutional costs. *Id.*, Attachment D. Thus, Ms. Anderson contends there will be no issue of subsidization of competitive products by market dominant products as a result of this contract. *Id.*

Related contract. A redacted version of the specific Express Mail & Priority Mail Contract 8 is included with the Request. The contract has an initial term of 3 years and is to be effective 1 day after the Commission provides all necessary regulatory approvals. The Postal Service represents that the contract is consistent with 39 U.S.C. 3633(a) and 39 CFR 3015.7(c). *See id.*, Attachment A and Attachment E. It notes that actual performance under this contract could vary from estimates, but concludes that the risks are manageable. *Id.*, Attachment A.

The Postal Service filed much of the supporting materials, including the Governors' Decision and the specific Express Mail & Priority Mail Contract 8, under seal. In its Request, the Postal Service maintains that the contract and related financial information, including the customer's name and the accompanying analyses that provide prices, terms, conditions, and financial projections should remain under seal. *Id.* at 2–3.

II. Notice of Filings

The Commission establishes Docket Nos. MC2009–33 and CP2009–44 for consideration of the Request pertaining to the proposed Express Mail & Priority Mail Contract 8 product and the related contract, respectively. In keeping with practice, these dockets are addressed on a consolidated basis for purposes of this Order; however, future filings should be made in the specific docket in which issues being addressed pertain.

Interested persons may submit comments on whether the Postal Service's filings in the captioned dockets are consistent with the policies of 39 U.S.C. 3632, 3633, or 3642 and 39 CFR part 3015 and 39 CFR part 3020 subpart B. Comments are due no later than July 15, 2009. The public portions of these filings can be accessed via the Commission's Web site (*http://www.prc.gov*).

The Commission appoints Paul L. Harrington to serve as Public Representative in these dockets.

III. Ordering Paragraphs

It is ordered:

1. The Commission establishes Docket Nos. MC2009–33 and CP2009–44 for consideration of the matters raised in each docket.

2. Pursuant to 39 U.S.C. 505, Paul L. Harrington is appointed to serve as officer of the Commission (Public Representative) to represent the

[1] Request of the United States Postal Service to Add Express Mail & Priority Mail Contract 8 to Competitive Product List and Notice of Establishment of Rates and Class Not of General Applicability, July 2, 2009.

[2] Errata to Request of the United States Postal Service to Add Express Mail & Priority Mail Contract 8 to Competitive Product List and Notice of Establishment of Rates and Class Not of General Applicability, July 6, 2009 (Request).

[3] Attachment A to the Request consists of the redacted Decision of the Governors of the United States Postal Service on Establishment of Rate and Class Not of General Applicability for Express Mail and Priority Mail Services (Governors' Decision No. 09–11). The Governors' Decision includes an attachment which provides an analysis of the proposed Express Mail and Priority Mail Contract 8 and certification of the Governors' vote. Attachment B is the redacted version of the contract. Attachment C shows the requested changes to the Mail Classification Schedule product list. Attachment D provides a Statement of Supporting Justification for the Request. Attachment E provides the certification of compliance with 39 U.S.C. 3633(a).

interests of the general public in these proceedings.

3. Comments by interested persons in these proceedings are due no later than July 15, 2009.

4. The Secretary shall arrange for publication of this order in the **Federal Register**.

Dated: July 7, 2009.

By the Commission.

Judith M. Grady,

Acting Secretary.

[FR Doc. E9–16622 Filed 7–10–09; 8:45 am]

BILLING CODE 7710–FW–P

POSTAL REGULATORY COMMISSION

[Docket Nos. MC2009–31 and CP2009–42; Order No. 239]

New Competitive Postal Product

AGENCY: Postal Regulatory Commission.

ACTION: Notice.

SUMMARY: The Commission is noticing a recently-filed Postal Service request to add Express Mail & Priority Mail Contract 6 to the Competitive Product List. The Postal Service has also filed a related contract. This notice addresses procedural steps associated with these filings.

DATES: Comments are due July 15, 2009.

ADDRESSES: Submit comments electronically via the Commission's Filing Online system at *http://www.prc.gov*.

FOR FURTHER INFORMATION CONTACT: Stephen L. Sharfman, General Counsel, 202–789–6820 and *stephen.sharfman@prc.gov*.

SUPPLEMENTARY INFORMATION:

I. Introduction

On July 2, 2009, the Postal Service filed a formal request pursuant to 39 U.S.C. 3642 and 39 CFR 3020.30 *et seq.* to add Express Mail & Priority Mail Contract 6 to the Competitive Product List.[1] On July 6, 2009, the Postal Service filed a revised version of its filing which includes attachments inadvertently omitted from the July 2, 2009 request.[2] The Postal Service asserts that the Express Mail & Priority Mail Contract 6 product is a competitive product ''not of general applicability'' within the meaning of 39 U.S.C. 3632(b)(3). *Id.* at 1. The Request has been assigned Docket No. MC2009–31.

The Postal Service contemporaneously filed a contract related to the proposed new product pursuant to 39 U.S.C. 3632(b)(3) and 39 CFR 3015.5. *Id.* at 2. The contract has been assigned Docket No. CP2009–42.

Request. The Request incorporates (1) A redacted version of the Governors' Decision authorizing the new product; (2) a redacted version of the contract; (3) requested changes to the Mail Classification Schedule product list; (4) a statement of supporting justification as required by 39 CFR 3020.32; and (5) certification of compliance with 39 U.S.C. 3633(a).[3] Substantively, the Request seeks to add Express Mail & Priority Mail Contract 6 to the Competitive Product List. Request at 1–2.

In the Statement of Supporting Justification, Mary Prince Anderson, Manager, Sales and Communications, Expedited Shipping, asserts that the service to be provided under the contract will cover its attributable costs, make a positive contribution to institutional costs, and increase contribution toward the requisite 5.5 percent of the Postal Service's total institutional costs. *Id.*, Attachment D. Thus, Ms. Anderson contends there will be no issue of subsidization of competitive products by market dominant products as a result of this contract. *Id.*

Related contract. A redacted version of the specific Express Mail & Priority Mail Contract 6 is included with the Request. The contract has an initial term of 3 years and is to be effective 1 day after the Commission provides all necessary regulatory approvals. The Postal Service represents that the contract is consistent with 39 U.S.C. 3633(a) and 39 CFR 3015.7(c). *See id.*, Attachment A and Attachment E. It notes that actual performance under this contract could vary from estimates, but concludes that the risks are manageable. *Id.*, Attachment A.

The Postal Service filed much of the supporting materials, including the Governors' Decision and the specific Express Mail & Priority Mail Contract 6, under seal. In its Request, the Postal Service maintains that the contract and related financial information, including the customer's name and the accompanying analyses that provide prices, terms, conditions, and financial projections should remain under seal. *Id.* at 2–3.

II. Notice of Filings

The Commission establishes Docket Nos. MC2009–31 and CP2009–42 for consideration of the Request pertaining to the proposed Express Mail & Priority Mail Contract 6 product and the related contract, respectively. In keeping with practice, these dockets are addressed on a consolidated basis for purposes of this Order; however, future filings should be made in the specific docket in which issues being addressed pertain.

Interested persons may submit comments on whether the Postal Service's filings in the captioned dockets are consistent with the policies of 39 U.S.C. 3632, 3633, or 3642 and 39 CFR part 3015 and 39 CFR part 3020 subpart B. Comments are due no later than July 15, 2009. The public portions of these filings can be accessed via the Commission's Web site (*http://www.prc.gov*).

The Commission appoints Paul L. Harrington to serve as Public Representative in these dockets.

III. Ordering Paragraphs

It is ordered:

1. The Commission establishes Docket Nos. MC2009–31 and CP2009–42 for consideration of the matters raised in each docket.

2. Pursuant to 39 U.S.C. 505, Paul L. Harrington is appointed to serve as officer of the Commission (Public Representative) to represent the interests of the general public in these proceedings.

3. Comments by interested persons in these proceedings are due no later than July 15, 2009.

1. The Secretary shall arrange for publication of this Order in the **Federal Register**.

Dated: July 7, 2009.

By the Commission.

Judith M. Grady,

Acting Secretary.

[FR Doc. E9–16632 Filed 7–10–09; 8:45 am]

BILLING CODE 7710–FW–P

[1] Request of the United States Postal Service to Add Express Mail & Priority Mail Contract 6 to Competitive Product List and Notice of Establishment of Rates and Class Not of General Applicability, July 2, 2009.

[2] Errata to Request of the United States Postal Service to Add Express Mail & Priority Mail Contract 6 to Competitive Product List and Notice of Establishment of Rates and Class Not of General Applicability, July 6, 2009 (Request).

[3] Attachment A to the Request consists of the redacted Decision of the Governors of the United States Postal Service on Establishment of Rate and Class Not of General Applicability for Express Mail and Priority Mail Services (Governors' Decision No. 09–9). The Governors' Decision includes an attachment which provides an analysis of the proposed Express Mail and Priority Mail Contract 6 and certification of the Governors' vote. Attachment B is the redacted version of the contract. Attachment C shows the requested changes to the Mail Classification Schedule product list. Attachment D provides a Statement of Supporting Justification for the Request. Attachment E provides the certification of compliance with 39 U.S.C. 3633(a).

POSTAL REGULATORY COMMISSION

[Docket Nos. MC2009–30 and CP2009–40; Order No. 234]

New Competitive Postal Product

AGENCY: Postal Regulatory Commission.

ACTION: Notice.

SUMMARY: The Commission is noticing a recently-filed Postal Service request to add Priority Mail Contract 14 to the Competitive Product List. The Postal Service has also filed a related contract. This notice addresses procedural steps associated with these filings.

DATES: Comments are due July 10, 2009.

ADDRESSES: Submit comments electronically via the Commission's Filing Online system at *http://www.prc.gov*.

FOR FURTHER INFORMATION CONTACT: Stephen L. Sharfman, General Counsel, 202–789–6820 and *stephen.sharfman@prc.gov*.

SUPPLEMENTARY INFORMATION:

I. Introduction

On June 29, 2009, the Postal Service filed a formal request pursuant to 39 U.S.C. 3642 and 39 CFR 3020.30 *et seq.* to add Priority Mail Contract 14 to the Competitive Product List.[1] The Postal Service asserts that Priority Mail Contract 14 is a competitive product ''not of general applicability'' within the meaning of 39 U.S.C. 3632(b)(3). *Id.* at 1. The Request has been assigned Docket No. MC2009–30.

The Postal Service contemporaneously filed a contract related to the proposed new product pursuant to 39 U.S.C. 3632(b)(3) and 39 CFR 3015.5. The contract has been assigned Docket No. CP2009–40.

Request. The Request includes (1) A redacted version of the Governors' Decision authorizing the new product; (2) a redacted version of the contract; (3) requested changes in the Mail Classification Schedule product list; (4) a statement of supporting justification as required by 39 CFR 3020.32; and (5) certification of compliance with 39 U.S.C. 3633(a).[2] Substantively, the Request seeks to add Priority Mail Contract 14 to the Competitive Product List. *Id.* at 1–2.

In the statement of supporting justification, Mary Prince Anderson, Acting Manager, Sales and Communications, Expedited Shipping, asserts that the service to be provided under the contract will cover its attributable costs, make a positive contribution to institutional costs, and increase contribution toward the requisite 5.5 percent of the Postal Service's total institutional costs. *Id.*, Attachment C. Thus, Ms. Anderson contends there will be no issue of subsidization of competitive products by market dominant products as a result of this contract. *Id.*

Related contract. A redacted version of the specific Priority Mail Contract 14 is included with the Request. The contract is for 3 years and is to be effective 1 day after the Commission provides all necessary regulatory approvals. The Postal Service represents that the contract is consistent with 39 U.S.C. 3633(a) and 39 CFR 3015.7(c). *See id.*, Attachment D.

The Postal Service filed much of the supporting materials, including the specific Priority Mail Contract 14, under seal. In its Request, the Postal Service maintains that the contract and related financial information, including the customer's name and the accompanying analyses that provide prices, terms, conditions, and financial projections should remain under seal. *Id.* at 2–3.

II. Notice of Filings

The Commission establishes Docket Nos. MC2009–30 and CP2009–40 for consideration of the Request pertaining to the proposed Priority Mail Contract 14 product and the related contract, respectively. In keeping with practice, these dockets are addressed on a consolidated basis for purposes of this Order; however, future filings should be made in the specific docket in which issues being addressed pertain.

Interested persons may submit comments on whether the Postal Service's filings in the captioned dockets are consistent with the policies of 39 U.S.C. 3632, 3633, or 3642 and 39 CFR part 3015 and 39 CFR part 3020 subpart B. Comments are due no later than July 10, 2009. The public portions of these filings can be accessed via the Commission's Web site (*http://www.prc.gov*).

The Commission appoints Paul L. Harrington to serve as Public Representative in these dockets.

III. Ordering Paragraphs

It is Ordered:

1. The Commission establishes Docket Nos. MC2009–30 and CP2009–40 for consideration of the matter raised in each docket.

2. Pursuant to 39 U.S.C. 505, Paul L. Harrington is appointed to serve as officer of the Commission (Public Representative) to represent the interests of the general public in these proceedings.

3. Comments by interested persons in these proceedings are due no later than July 10, 2009.

4. The Secretary shall arrange for publication of this order in the **Federal Register**.

Dated: July 1, 2009.

By the Commission.

Judith M. Grady,

Acting Secretary.

[FR Doc. E9–16583 Filed 7–10–09; 8:45 am]

BILLING CODE P

POSTAL REGULATORY COMMISSION

[Docket Nos. MC2009–32 and CP2009–43; Order No. 240]

New Competitive Postal Product

AGENCY: Postal Regulatory Commission.

ACTION: Notice.

SUMMARY: The Commission is noticing a recently-filed Postal Service request to add Express Mail & Priority Mail Contract 7 to the Competitive Product List. The Postal Service has also filed a related contract. This notice addresses procedural steps associated with these filings.

DATES: Comments are due July 15, 2009.

ADDRESSES: Submit comments electronically via the Commission's Filing Online system at *http://www.prc.gov*.

FOR FURTHER INFORMATION CONTACT: Stephen L. Sharfman, General Counsel, 202–789–6820 and *stephen.sharfman@prc.gov*.

SUPPLEMENTARY INFORMATION:

I. Introduction

On July 2, 2009, the Postal Service filed a formal request pursuant to 39 U.S.C. 3642 and 39 CFR 3020.30 *et seq.* to add Express Mail & Priority Mail Contract 7 to the Competitive Product List.[1] On July 6, 2009, the Postal Service

[1] Request of the United States Postal Service to Add Priority Mail Contract 14 to Competitive Product List and Notice of Filing (Under Seal) of Contract and Supporting Data, June 29, 2009 (Request).

[2] The redacted Decision of the Governors of the United States Postal Service on Establishment of Rate and Class Not of General Applicability for Priority Mail Service (Governors' Decision No. 09–6) was filed in Docket No. MC2009–25 and is incorporated in this case by reference. Attachment A to the Request is the redacted version of the contract. Attachment B shows the requested changes to the Mail Classification Schedule product list. Attachment C provides a statement of supporting justification for this Request. Attachment D provides the certification of compliance with 39 U.S.C. 3633(a).

[1] Request of the United States Postal Service to Add Express Mail & Priority Mail Contract 7 to

filed a revised version of its filing which includes attachments inadvertently omitted from the July 2, 2009 request.[2] The Postal Service asserts that the Express Mail & Priority Mail Contract 7 product is a competitive product ''not of general applicability'' within the meaning of 39 U.S.C. 3632(b)(3). *Id.* at 1. The Request has been assigned Docket No. MC2009–32.

The Postal Service contemporaneously filed a contract related to the proposed new product pursuant to 39 U.S.C. 3632(b)(3) and 39 CFR 3015.5. *Id.* at 2. The contract has been assigned Docket No. CP2009–43.

Request. The Request incorporates (1) A redacted version of the Governors' Decision authorizing the new product; (2) a redacted version of the contract; (3) requested changes to the Mail Classification Schedule product list; (4) a statement of supporting justification as required by 39 CFR 3020.32; and (5) certification of compliance with 39 U.S.C. 3633(a).[3] Substantively, the Request seeks to add Express Mail & Priority Mail Contract 7 to the Competitive Product List. Request at 1–2.

In the Statement of Supporting Justification, Mary Prince Anderson, Manager, Sales and Communications, Expedited Shipping, asserts that the service to be provided under the contract will cover its attributable costs, make a positive contribution to institutional costs, and increase contribution toward the requisite 5.5 percent of the Postal Service's total institutional costs. *Id.*, Attachment D. Thus, Ms. Anderson contends there will be no issue of subsidization of competitive products by market dominant products as a result of this contract. *Id.*

Related contract. A redacted version of the specific Express Mail & Priority Mail Contract 7 is included with the Request. The contract has an initial term of 3 years and is to be effective 1 day after the Commission provides all necessary regulatory approvals. The Postal Service represents that the contract is consistent with 39 U.S.C. 3633(a) and 39 CFR 3015.7(c). *See id.*, Attachment A and Attachment E. It notes that actual performance under this contract could vary from estimates, but concludes that the risks are manageable. *Id.*, Attachment A.

The Postal Service filed much of the supporting materials, including the Governors' Decision and the specific Express Mail & Priority Mail Contract 7, under seal. In its Request, the Postal Service maintains that the contract and related financial information, including the customer's name and the accompanying analyses that provide prices, terms, conditions, and financial projections should remain under seal. *Id.* at 2–3.

II. Notice of Filings

The Commission establishes Docket Nos. MC2009–32 and CP2009–43 for consideration of the Request pertaining to the proposed Express Mail & Priority Mail Contract 7 product and the related contract, respectively. In keeping with practice, these dockets are addressed on a consolidated basis for purposes of this Order; however, future filings should be made in the specific docket in which issues being addressed pertain.

Interested persons may submit comments on whether the Postal Service's filings in the captioned dockets are consistent with the policies of 39 U.S.C. 3632, 3633, or 3642 and 39 CFR part 3015 and 39 CFR 3020 subpart B. Comments are due no later than July 15, 2009. The public portions of these filings can be accessed via the Commission's Web site (*http://www.prc.gov*).

The Commission appoints Paul L. Harrington to serve as Public Representative in these dockets.

III. Ordering Paragraphs

It is ordered:

1. The Commission establishes Docket Nos. MC2009–32 and CP2009–43 for consideration of the matters raised in each docket.

2. Pursuant to 39 U.S.C. 505, Paul L. Harrington is appointed to serve as officer of the Commission (Public Representative) to represent the interests of the general public in these proceedings.

3. Comments by interested persons in these proceedings are due no later than July 15, 2009.

4. The Secretary shall arrange for publication of this Order in the **Federal Register**.

Dated: July 7, 2009.

By the Commission.

Judith M. Grady,

Acting Secretary.

[FR Doc. E9–16621 Filed 7–10–09; 8:45 am]

BILLING CODE 7710–FW–P

Competitive Product List and Notice of Establishment of Rates and Class Not of General Applicability, July 2, 2009.

[2] Errata to Request of the United States Postal Service to Add Express Mail & Priority Mail Contract 7 to Competitive Product List and Notice of Establishment of Rates and Class Not of General Applicability, July 6, 2009. (Request).

[3] Attachment A to the Request consists of the redacted Decision of the Governors of the United States Postal Service on Establishment of Rate and Class Not of General Applicability for Express Mail and Priority Mail Services (Governors' Decision No. 09–10). The Governors' Decision includes an attachment which provides an analysis of the proposed Express Mail and Priority Mail Contract 7 and certification of the Governors' vote. Attachment B is the redacted version of the contract. Attachment C shows the requested changes to the Mail Classification Schedule product list. Attachment D provides a Statement of Supporting Justification for the Request. Attachment E provides the certification of compliance with 39 U.S.C. 3633(a).

POSTAL REGULATORY COMMISSION

[Docket Nos. MC2009–34 and CP2009–45; Order No. 242]

New Competitive Postal Product

AGENCY: Postal Regulatory Commission.

ACTION: Notice.

SUMMARY: The Commission is noticing a recently-filed Postal Service request to add Express Mail Contract 4 to the Competitive Product List. The Postal Service has also filed a related contract. This notice addresses procedural steps associated with these filings.

DATES: Comments are due July 15, 2009.

ADDRESSES: Submit comments electronically via the Commission's Filing Online system at *http://www.prc.gov*.

FOR FURTHER INFORMATION CONTACT: Stephen L. Sharfman, General Counsel, 202–789–6820 and *stephen.sharfman@prc.gov*.

SUPPLEMENTARY INFORMATION:

I. Introduction

On July 6, 2009, the Postal Service filed a formal request pursuant to 39 U.S.C. 3642 and 39 CFR 3020.30 *et seq.* to add Express Mail Contract 4 to the Competitive Product List.[1] The Postal Service asserts that the Express Mail Contract 4 product is a competitive product ''not of general applicability'' within the meaning of 39 U.S.C. 3632(b)(3). *Id.* at 1. The Request has been assigned Docket No. MC2009–34.

The Postal Service contemporaneously filed a contract related to the proposed new product pursuant to 39 U.S.C. 3632(b)(3) and 39 CFR 3015.5. *Id.* at 2. The contract is assigned Docket No. CP2009–45.

Request. The Request incorporates (1) A redacted version of the Governors' Decision authorizing the new product; (2) a redacted version of the contract; (3) requested changes in the Mail Classification Schedule product list; (4)

[1] Request of the United States Postal Service to Add Express Mail Contract 4 to Competitive Product List and Notice of Establishment of Rates and Class Not of General Applicability, July 6, 2009 (Request).

a Statement of Supporting Justification as required by 39 CFR 3020.32; and (5) certification of compliance with 39 U.S.C. 3633(a).[2] Substantively, the Request asks the Commission to add the Express Mail Contract 4 product to the Competitive Product List. *Id.* at 1–2.

In the Statement of Supporting Justification, Mary Prince Anderson, Manager, Sales and Communications, Expedited Shipping, asserts that the service to be provided under the contract will cover its attributable costs, make a positive contribution to institutional costs, and increase contribution toward the requisite 5.5 percent of the Postal Service's total institutional costs. *Id.*, Attachment D. Thus, Ms. Anderson contends there will be no issue of subsidization of competitive products by market dominant products as a result of this contract. *Id.*

Related contract. A redacted version of the specific Express Mail Contract 4 is included with the Request. The contract is for 3 years and is to be effective the day following the date on which the Commission provides all necessary regulatory approvals. The Postal Service represents that the contract is consistent with 39 U.S.C. 3633(a) and 39 CFR 3015.7(c). *See id.*, Attachment to Governors' Decision and Attachment E. It notes that performance under this contract could vary from estimates, but concludes that the risks are manageable, and overall the contract is expected to generate significant contribution. *Id.*, Attachment to Governors' Decision.

The Postal Service filed much of the supporting materials, including the Governors' Decision and the specific Express Mail Contract 4, under seal. In its Request, the Postal Service maintains that the contract and related financial information, including the customer's name and the accompanying analyses that provide prices, terms, conditions, and financial projections should remain under seal. *Id.* at 2–3.

II. Notice of Filings

The Commission establishes Docket Nos. MC2009–34 and CP2009–45 for consideration of the Request pertaining to the proposed Express Mail Contract 4 product and the related contract, respectively. In keeping with practice, these dockets are addressed on a consolidated basis for purposes of this order; however, future filings should be made in the specific docket in which issues being addressed pertain.

Interested persons may submit comments on whether the Postal Service's filings in the captioned dockets are consistent with the policies of 39 U.S.C. 3632, 3633, or 3642 and 39 CFR part 3015 and 39 CFR part 3020 subpart B. Comments are due no later than July 15, 2009. The public portions of these filings can be accessed via the Commission's Web site (*http://www.prc.gov*).

The Commission appoints Cassandra Hicks to serve as Public Representative in these dockets.

III. Ordering Paragraphs

It is ordered:

1. The Commission establishes Docket Nos. MC2009–34 and CP2009–45 for consideration of the matters raised in each respective docket.

2. Pursuant to 39 U.S.C. 505, Cassandra Hicks is appointed to serve as officer of the Commission (Public Representative) to represent the interests of the general public in these proceedings.

3. Comments by interested persons in these proceedings are due no later than July 15, 2009.

4. The Secretary shall arrange for publication of this order in the **Federal Register**.

Dated: July 7, 2009.

By the Commission.

Judith M. Grady,

Acting Secretary.

[FR Doc. E9–16637 Filed 7–10–09; 8:45 am]

BILLING CODE 7710–FW–P

[2] Attachment A to the Request consists of the redacted Decision of the Governors of the United States Postal Service on Establishment of Rate and Class Not of General Applicability for Express Mail Service (Governors' Decision No. 09–8). The Governors' Decision includes an attachment which provides an analysis of the proposed Express Mail Contract 4 and certification of the Governors' vote. Attachment B is the redacted version of the contract. Attachment C shows the requested changes to the Mail Classification Schedule product list. Attachment D provides a statement of supporting justification for this Request. Attachment E provides the certification of compliance with 39 U.S.C. 3633(a).

POSTAL REGULATORY COMMISSION

[Docket No. A2009–1; Order No. 238]

Post Office Closing

AGENCY: Postal Regulatory Commission.

ACTION: Notice.

SUMMARY: This document informs the public that an appeal of the closing of the Hacker Valley, WV post office has been filed. It identifies preliminary steps and provides a procedural schedule. Publication of this document will allow the Postal Service, petitioner, and others to take appropriate action.

ADDRESSES: Submit comments electronically via the Commission's Filing Online system at *http://www.prc.gov.*

FOR FURTHER INFORMATION CONTACT: Stephen L. Sharfman, General Counsel, 202–789–6820 and *stephen.sharfman@prc.gov*.

SUPPLEMENTARY INFORMATION:

Notice is hereby given that pursuant to 39 U.S.C. 404(d), the Commission has received an appeal of the closing of the Hacker Valley Post Office, Hacker Valley, West Virginia 26222. The appeal, which was received by the Commission June 30, 2009, was postmarked June 20, 2009 and, therefore, is deemed constructively filed on that date.[1] The appeal was filed as a Participant Statement on PRC Form 61. Petitioner will have the option of filing supplemental information or facts by August 4, 2009. The Commission hereby institutes a proceeding under 39 U.S.C. 404(d)(5) and designates the case as Docket No. A2009–1 to consider the petitioner's appeal.

Categories of issues raised. The categories of issues that appear to be raised include:

1. Effect on the community (39 U.S.C. 404(d)(2)(A)(i)); and

2. Effect on employees (39 U.S.C. 404(d)(2)(A)(ii)).

After the Postal Service files the administrative record and the Commission reviews it, the Commission may find that there are more legal issues than those set forth above or that the Postal Service's determination disposes of one or more of those issues. The deadline for the Postal Service to file the administrative record with the Commission is July 15, 2009. 39 CFR 3001.113.

Availability; Web site posting. The Commission has posted the appeal and supporting material on its Web site at *http://www.prc.gov*. Additional filings in this case and participants' submissions also will be posted on the Web site, if provided in electronic format or amenable to conversion, and not subject to a valid protective order. Information on how to use the Commission's Web site is available online or by contacting the Commission's webmaster via telephone at 202–789–6873 or electronic mail at *PRC-WEBMASTER@prc.gov*.

The appeal and all related documents are also available for public inspection in the Commission's docket section. Docket section hours are 8 a.m. to 4:30

[1] The Postal Accountability and Enhancement Act section 1006 amends 39 U.S.C. 404(d) to provide that an appeal sent through the mails is deemed received by the Commission on the date of the postmark on the envelope in which the appeal is mailed.

p.m., Monday through Friday, except on Federal government holidays. Docket section personnel may be contacted via electronic mail at *prc-docket@prc.gov* or via telephone at 202–789–6846.

Filing of documents. All filing of documents in this case shall be made using the Internet (Filing Online) pursuant to Commission rules 9(a) and 10(a) at the Commission's Web site, *http://www.prc.gov*, unless a waiver is obtained. 39 CFR 3001.9(a) and 10(a). Instructions for obtaining an account to file documents online may be found on the Commission's Web site, *http://www.prc.gov*, or by contacting the Commission's docket section at *prc-docket@prc.gov* or via telephone at 202–789–6846. The Commission waives the Filing Online requirement for the petitioner.

Intervention. Those, other than the petitioner and respondent, wishing to be heard in this matter are directed to file a notice of intervention on or before July 31, 2009 in accordance with 39 CFR 3001.111(b). The notice of intervention shall be filed using the Internet (Filing Online) at the Commission's Web site, *http://www.prc.gov*, or by waiver obtained for hardcopy filing. *See* 39 CFR 3001.9(a) and 10(a).

Public Representative. Richard A. Oliver is designated as the Public Representative to represent the interests of the general public.

Further procedures. By statute the Commission is required to issue its decision within 120 days from the date this appeal was filed. *See* 39 U.S.C. 404(d)(5). A procedural schedule has been developed to accommodate this statutory deadline.[2] In the interest of expedition and in light of the 120-day decision schedule, the Commission may request the Postal Service or other participants to provide more information or to submit memoranda of law on any appropriate issue. As required by the Commission rules, if any motions are filed, responses are due 7 days after any such motion is filed. *See* 39 CFR 3001.21.

It is ordered:

1. The Postal Service shall file the administrative record in this appeal or otherwise file a responsive pleading to the appeal by July 15, 2009.

2. The procedural schedule to this order is listed below and hereby adopted.

3. The petitioner is granted a waiver from Online Filing.

4. Pursuant to 39 U.S.C. 505, Richard A. Oliver is designated officer of the Commission (Public Representative) to represent the interests of the general public.

5. The Secretary shall arrange for publication of this notice and order and procedural schedule in the **Federal Register**.

PROCEDURAL SCHEDULE

June 20, 2009	Filing of Appeal.
July 15, 2009	Deadline for Postal Service to file administrative record in this appeal or responsive pleading.
July 31, 2009	Deadline for filing petitions to intervene (*see* 39 CFR 3001.111(b)).
August 4, 2009	Deadline for supplemental information or facts and/or initial briefs in support of petition (*see* 39 CFR 3001.115(a), (b) and (e)).
August 24, 2009	Deadline for answering brief in support of Postal Service (*see* 39 CFR 3001.115(c)).
September 8, 2009	Deadline for reply briefs in response to answering briefs (*see* 39 CFR 3001.115(d)).
September 15, 2009	Deadline for motions requesting oral argument; the Commission will schedule oral argument only when it is a necessary addition to the written filings (*see* 39 CFR 3001.116).
October 18, 2009	Expiration of the Commission 120-day decisional schedule (*see* 39 U.S.C. 404(d)(5)).

Dated: July 6, 2009.

By the Commission.

Judith M. Grady,

Secretary.

[FR Doc. E9–16620 Filed 7–10–09; 8:45 am]

BILLING CODE 7710–FW–P

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration #11750 and #11751]

West Virginia Disaster Number WV–00012

AGENCY: U.S. Small Business Administration.

ACTION: Amendment 4.

SUMMARY: This is an amendment of the Presidential declaration of a major disaster for the State of West Virginia (FEMA–1838–DR), dated 05/15/2009.

Incident: Severe storms, flooding, mudslides, and landslides.

Incident Period: 05/03/2009 through 06/08/2009.

DATES: *Effective Date:* 07/01/2009.

Physical Loan Application Deadline Date: 07/14/2009.

EIDL Loan Application Deadline Date: 02/15/2010.

ADDRESSES: Submit completed loan applications to: U.S. Small Business Administration, Processing and Disbursement Center, 14925 Kingsport Road, Fort Worth, TX 76155.

FOR FURTHER INFORMATION CONTACT: A. Escobar, Office of Disaster Assistance, U.S. Small Business Administration, 409 3rd Street, SW., Suite 6050, Washington, DC 20416.

SUPPLEMENTARY INFORMATION: The notice of the Presidential disaster declaration for the State of West Virginia, dated 05/15/2009 is hereby amended to include the following areas as adversely affected by the disaster:

Primary Counties: (Physical Damage and Economic Injury Loans): Mercer.

Contiguous Counties: (Economic Injury Loans Only):

Virginia: Bland, Giles.

All other information in the original declaration remains unchanged.

[2] Given the difference between the Commission's actual and constructive receipt of the appeal, the procedural schedule is developed based on the date the appeal was actually received, except for the due date of the Commission's decision. This will afford participants sufficient time to develop the record without compromising the Commission's ability to issue a timely decision. Intervenor statements or briefs, including from the Public Representative, are due within the time allowed for such statements or initial, reply, or answering briefs as appropriate.

(Catalog of Federal Domestic Assistance Numbers 59002 and 59008)

James E. Rivera,

Acting Associate Administrator for Disaster Assistance.

[FR Doc. E9–16392 Filed 7–10–09; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration #11778 and #11779]

Alaska Disaster Number AK–00016

AGENCY: U.S. Small Business Administration.

ACTION: Amendment 2.

SUMMARY: This is an amendment of the Presidential declaration of a major disaster for Public Assistance Only for the State of Alaska (FEMA–1843–DR), dated 06/11/2009.

Incident: Flooding and ice jams.

Incident Period: 04/28/2009 through 05/31/2009.

Effective Date: 07/01/2009.

Physical Loan Application Deadline Date: 08/10/2009.

Economic Injury (EIDL) Loan Application Deadline Date: 03/11/2010.

ADDRESSES: Submit completed loan applications to: U.S. Small Business Administration, Processing and Disbursement Center, 14925 Kingsport Road, Fort Worth, TX 76155.

FOR FURTHER INFORMATION CONTACT: A. Escobar, Office of Disaster Assistance, U.S. Small Business Administration, 409 3rd Street, SW., Suite 6050, Washington, DC 20416.

SUPPLEMENTARY INFORMATION: The notice of the President's major disaster declaration for Private Non-Profit organizations in the State of Alaska, dated 06/11/2009, is hereby amended to include the following areas as adversely affected by the disaster.

Primary Counties: Lower Yukon REAA (32), Yukon-Koyukuk REAA (52).

All other information in the original declaration remains unchanged.

(Catalog of Federal Domestic Assistance Numbers 59002 and 59008)

James E. Rivera,

Acting Associate Administrator for Disaster Assistance.

[FR Doc. E9–16406 Filed 7–10–09; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration #11776 and #11777]

Alaska Disaster Number AK–00015

AGENCY: U.S. Small Business Administration.

ACTION: Amendment 2.

SUMMARY: This is an amendment of the Presidential declaration of a major disaster for the State of Alaska (FEMA–1843–DR), dated 06/11/2009.

Incident: Flooding and ice jams.

Incident Period: 04/28/2009 through 05/31/2009.

Effective Date: 07/01/2009.

Physical Loan Application Deadline Date: 08/10/2009.

EIDL Loan Application Deadline Date: 03/11/2010.

ADDRESSES: Submit completed loan applications to: U.S. Small Business Administration, Processing And Disbursement Center, 14925 Kingsport Road, Fort Worth, TX 76155.

FOR FURTHER INFORMATION CONTACT: A. Escobar, Office of Disaster Assistance, U.S. Small Business Administration, 409 3rd Street, SW., Suite 6050, Washington, DC 20416.

SUPPLEMENTARY INFORMATION: The notice of the Presidential disaster declaration for the State of Alaska, dated 06/11/2009 is hereby amended to include the following areas as adversely affected by the disaster:

Primary REAAs (Physical Damage and Economic Injury Loans):

Lower Yukon REAA (32) Yupiit REAA (54)

All other REAAs and boroughs contiguous to the above named primary REAAs have previously been declared. All other information in the original declaration remains unchanged.

(Catalog of Federal Domestic Assistance Numbers 59002 and 59008)

James E. Rivera,

Acting Associate Administrator for Disaster Assistance.

[FR Doc. E9–16408 Filed 7–10–09; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration #11778 and #11779]

Alaska Disaster Number AK–00016

AGENCY: U.S. Small Business Administration.

ACTION: Amendment 1.

SUMMARY: This is an amendment of the Presidential declaration of a major disaster for Public Assistance Only for the State of Alaska (FEMA–1843–DR), dated 06/11/2009 .

Incident: Flooding and ice jams.

Incident Period: 04/28/2009 through 05/31/2009.

Effective Date: 05/31/2009.

Physical Loan Application Deadline Date: 08/10/2009.

Economic Injury (EIDL) Loan Application Deadline Date: 03/11/2010.

ADDRESSES: Submit completed loan applications to: U.S. Small Business Administration, Processing and Disbursement Center, 14925 Kingsport Road, Fort Worth, TX 76155.

FOR FURTHER INFORMATION CONTACT: A Escobar, Office of Disaster Assistance, U.S. Small Business Administration, 409 3rd Street, SW., Suite 6050, Washington, DC 20416.

SUPPLEMENTARY INFORMATION: The notice of the President's major disaster declaration for Private Non-Profit organizations in the State of Alaska, dated 06/11/2009, is hereby amended to establish the incident period for this disaster as beginning 04/28/2009 and continuing through 05/31/2009.

All other information in the original declaration remains unchanged.

(Catalog of Federal Domestic Assistance Numbers 59002 and 59008)

James E. Rivera,

Acting Associate Administrator for Disaster Assistance.

[FR Doc. E9–16404 Filed 7–10–09; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration #11776 and #11777]

Alaska Disaster Number AK–00015

AGENCY: U.S. Small Business Administration.

ACTION: Amendment 1.

SUMMARY: This is an amendment of the Presidential declaration of a major disaster for the State of Alaska (FEMA–1843–DR), dated 06/11/2009.

Incident: Flooding and Ice Jams.

Incident Period: 04/28/2009 and continuing through 05/31/2009.

Effective Date: 05/31/2009.

Physical Loan Application Deadline Date: 08/10/2009.

EIDL Loan Application Deadline Date: 03/11/2010.

ADDRESSES: Submit completed loan applications to: U.S. Small Business Administration, Processing and Disbursement Center, 14925 Kingsport Road, Fort Worth, TX 76155.

FOR FURTHER INFORMATION CONTACT: A. Escobar, Office of Disaster Assistance, U.S. Small Business Administration, 409 3rd Street, SW., Suite 6050, Washington, DC 20416.

SUPPLEMENTARY INFORMATION: The notice of the President's major disaster declaration for the State of Alaska, dated 06/11/2009 is hereby amended to establish the incident period for this

disaster as beginning 04/28/2009 and continuing through 05/31/2009.

All other information in the original declaration remains unchanged.

(Catalog of Federal Domestic Assistance Numbers 59002 and 59008)

James E. Rivera,

Acting Associate Administrator for Disaster Assistance.

[FR Doc. E9–16393 Filed 7–10–09; 8:45 am]

BILLING CODE 8025–01–P

SECURITIES AND EXCHANGE COMMISSION

Submission for OMB Review; Comment Request

Upon Written Request, Copies Available From: Securities and Exchange Commission, Office of Investor Education and Advocacy, Washington, DC 20549–0213.

Extension:

Rule 27f–1 and Form N–27F–1, SEC File No. 270–487, OMB Control No. 3235–0546.

Notice is hereby given that, pursuant to the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*), the Securities and Exchange Commission (the ''Commission'') has submitted to the Office of Management and Budget a request for extension of the previously approved collection of information discussed below.

Section 27(f) of the Investment Company Act of 1940 (''Act'') (15 U.S.C. 80a–27(f)) provides that ''[w]ith respect to any periodic payment plan (other than a plan under which the amount of sales load deducted from any payment thereon does not exceed 9 per centum of such payment), the custodian bank for such plan shall mail to each certificate holder, within sixty days after the issuance of the certificate, a statement of charges to be deducted from the projected payments on the certificate and a notice of his right of withdrawal as specified in this section.'' [1] The certificate holder then has forty-five days from the mailing of the notice to surrender his or her certificate and receive ''in payment thereof, in cash, the sum of (1) the value of his account, and (2) an amount, from the underwriter or depositor, equal to the difference between the gross payments made and the net amount invested.''

Section 27(f) authorizes the Securities and Exchange Commission (''Commission'') to ''make rules specifying the method, form, and contents of the notice required by this subsection.'' Rule 27f–1 (17 CFR 270.27f–1) under the Act, entitled ''Notice of Right of Withdrawal Required to be Mailed to Periodic Payment Plan Certificate Holders and Exemption from Section 27(f) for Certain Periodic Payment Plan Certificates,'' provides instructions for the delivery of the notice required by section 27(f).

Rule 27f–1(d) prescribes Form N–27F–1 (17 CFR 274.127f–1), which sets forth the language that custodian banks for periodic payment plans must use in informing certificate holders of their withdrawal right pursuant to section 27(f). The instructions to the form provide that the notice must be on the sender's letterhead. The Commission does not receive a copy of the Form N–27F–1 notice.

The Form N–27F–1 notice informs certificate holders of their rights in connection with the certificates they hold. Specifically, it is intended to encourage new purchasers of plan certificates to reassess the costs and benefits of their investment and to provide them with an opportunity to recover their initial investment without penalty. The disclosure assists certificate holders in making careful and fully informed decisions about whether to invest in periodic payment plan certificates.

Complying with the collection of information requirements of rule 27f–1 is mandatory for custodian banks of periodic payment plans for which the sales load deducted from any payment exceeds 9 percent of the payment.[2] The information provided pursuant to rule 27f–1 will be provided to third parties and, therefore, will not be kept confidential. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid control number.

Effective October 27, 2006, the Military Personnel Financial Services Protection Act banned the issuance or sale of new periodic payment plans. Accordingly, the staff estimates that there is no information collection burden associated with rule 27f–1 and Form N–27F–1. For administrative purposes, however, we are requesting approval for an information collection burden of one hour per year. This estimate of burden hours is not derived from a comprehensive or necessarily even representative study of the cost of the Commission's rules and forms.

Please direct general comments regarding the above information to the following persons: (i) Desk Officer for the Securities and Exchange Commission, Office of Management and Budget, Room 10102, New Executive Office Building, Washington, DC 20503 or send an e-mail to Shagufta Ahmed at *Shagufta_Ahmed@omb.eop.gov*; and (ii) Charles Boucher, Director/CIO, Securities and Exchange Commission, C/O Shirley Martinson, 6432 General Green Way, Alexandria, VA 22312; or send an e-mail to: *PRA_Mailbox@sec.gov*. Comments must be submitted to OMB within 30 days of this notice.

Dated: July 6, 2009.

Elizabeth M. Murphy,

Secretary.

[FR Doc. E9–16387 Filed 7–10–09; 8:45 am]

BILLING CODE 8010–01–P

SECURITIES AND EXCHANGE COMMISSION

Proposed Collection; Comment Request

Upon Written Request, Copies Available From: Securities and Exchange Commission, Office of Investor Education and Advocacy, Washington, DC 20549–0212.

Extension:

Rules 8b–1 to 8b–33; SEC File No. 270–135; OMB Control No. 3235–0176.

Notice is hereby given that, pursuant to the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*), the Securities and Exchange Commission (the ''Commission'') is soliciting comments on the collection of information summarized below. The Commission plans to submit this existing collection of information to the Office of Management and Budget for extension and approval.

Rules 8b–1 to 8b–33 (17 CFR 270.8b–1 to 8b–33) under the Investment Company Act of 1940 (15 U.S.C. 80a–1 *et seq.*) (the ''Act'') are the procedural rules an investment company must follow when preparing and filing a registration statement. These rules were adopted to standardize the mechanics of registration under the Act and to provide more specific guidance for persons registering under the Act than the information contained in the statute. For the most part, these procedural rules do not require the disclosure of

[1] As discussed below, the Military Personnel Financial Services Protection Act banned the issuance or sale of new periodic payment plans, effective October 2006.

[2] The rule also permits the issuer, its principal underwriter, its depositor, or its recordkeeping agent to mail the notice if the custodian bank has delegated the mailing of the notice to any of them or if the issuer has been permitted to operate without a custodian bank by Commission order. *See* 17 CFR 270.27f–1.

information. Two of the rules, however, require limited disclosure of information.[1] The information required by the rules is necessary to ensure that investors have clear and complete information upon which to base an investment decision. The Commission uses the information that investment companies provide on registration statements in its regulatory, disclosure review, inspection and policy-making roles. The respondents to the collection of information are investment companies filing registration statements under the Act.

The Commission does not estimate separately the total annual reporting and recordkeeping burden associated with rules 8b–1 to 8b–33 because the burden associated with these rules is included in the burden estimates the Commission submits for the investment company registration statement forms (*e.g.,* Form N–1A (17 CFR 239.15A and 274.11A), Form N–2 (17 CFR 239.14 and 274.11a–1), Form N–3 (17 CFR 239.17a and 274.11b), Form N–4 (17 CFR 239.17b and 274.11c), and Form N–6 (17 CFR 239.17c and 274.11d)). For example, a mutual fund that prepares a registration statement on Form N–1A must comply with the rules under section 8(b), including rules on riders, amendments, the form of the registration statement, and the number of copies to be submitted. Because the fund only incurs a burden from the section 8(b) rules when preparing a registration statement, it would be impractical to measure the compliance burden of these rules separately. The Commission believes that including the burden of the section 8(b) rules with the burden estimates for the investment company registration statement forms provides a more accurate and complete estimate of the total burdens associated with the registration process. For administrative purposes, however, we are requesting approval for an information collection burden of one hour per year. This estimate of burden hours is not derived from a comprehensive or necessarily even representative study of the cost of the Commission's rules and forms.

Written comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; (b) the accuracy of the agency's estimate of the burden of the collection of information; (c) ways to enhance the quality, utility, and clarity of the information collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Consideration will be given to comments and suggestions submitted in writing within 60 days of this publication.

Please direct your written comments to Charles Boucher, Director/CIO, Securities and Exchange Commission, C/O Shirley Martinson, 6432 General Green Way, Alexandria, VA 22312; or send an e-mail to: *PRA_Mailbox@sec.gov.*

Dated: July 8, 2009.

Elizabeth M. Murphy,

Secretary.

[FR Doc. E9–16479 Filed 7–10–09; 8:45 am]

BILLING CODE 8010–01–P

[1] Rule 8b–3 (17 CFR 270.8b–3) provides that whenever a registration form requires the title of securities to be stated, the registrant must indicate the type and general character of the securities to be issued. Rule 8b–22 (17 CFR 270.8b–22) provides that if the existence of control is open to reasonable doubt, the registrant may disclaim the existence of control, but it must state the material facts pertinent to the possible existence of control.

SECURITIES AND EXCHANGE COMMISSION

[Release Nos. 33–9049; 34–60260; File No. 265–25]

Investor Advisory Committee; Meeting

AGENCY: Securities and Exchange Commission.

ACTION: Notice of Meeting of SEC Investor Advisory Committee.

SUMMARY: The Securities and Exchange Commission Investor Advisory Committee is providing notice that it will hold a public meeting on Monday, July 27, 2009, in the Auditorium, Room L–002, at the Commission's main offices, 100 F Street, NE., Washington, DC. The meeting will begin at 10 a.m. (EST) and will be open to the public. The meeting will be webcast on the Commission's Web site at *http://www.sec.gov.* Persons needing special accommodations to take part because of a disability should notify a contact person listed below. The public is invited to submit written statements to the Committee.

The agenda for the meeting includes opening remarks, introduction of Committee members, discussion of Committee agenda and organization, and discussion of investor views of possible refinements to the disclosure regime.

DATES: Written statements should be received on or before July 19, 2009.

ADDRESSES: Written statements may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet submission form (*http://www.sec.gov/rules/other.shtml*); or
- Send an e-mail message to *rule-comments@sec.gov.* Please include File Number 265–25 on the subject line.

Paper Comments

- Send paper statements in triplicate to Elizabeth M. Murphy, Federal Advisory Committee Management Officer, Securities and Exchange Commission, 100 F Street, NE., Washington, DC 20549–1090.

All submissions should refer to File No. 265–25. This file number should be included on the subject line if e-mail is used. To help us process and review your statements more efficiently, please use only one method. The Commission staff will post all statements on the Advisory Committee's Web site (*http://www.sec.gov/spotlight/investoradvisorycommittee.htm*). Statements also will be available for public inspection and copying in the Commission's Public Reference Room, 100 F Street, NE., Washington, DC 20549, on official business days between the hours of 10 a.m. and 3 p.m. All statements received will be posted without change; we do not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly.

FOR FURTHER INFORMATION CONTACT: Kayla J. Gillan, Deputy Chief of Staff, at (202) 551–2100; David Fredrickson, Assistant General Counsel, Office of the General Counsel, at (202) 551–5144; or Owen Donley, Chief Counsel, Office of Investor Education and Advocacy, at (202) 551–6322, Securities and Exchange Commission, 100 F Street, NE., Washington, DC 20549–6561.

SUPPLEMENTARY INFORMATION: In accordance with Section 10(a) of the Federal Advisory Committee Act, 5 U.S.C. App. 1, section 10(a), Kayla J. Gillan, Designated Federal Officer of the Committee, has approved publication of this notice.

Dated: July 8, 2009.

Elizabeth M. Murphy,

Committee Management Officer.

[FR Doc. E9–16503 Filed 7–10–09; 8:45 am]

BILLING CODE 8010–01–P

SECURITIES AND EXCHANGE COMMISSION

Sunshine Act Meeting

Notice is hereby given, pursuant to the provisions of the Government in the Sunshine Act, Public Law 94–409, that the Securities and Exchange Commission will hold a Closed Meeting on Thursday, July 16, 2009 at 2 p.m.

Commissioners, Counsel to the Commissioners, the Secretary to the Commission, and recording secretaries will attend the Closed Meeting. Certain staff members who have an interest in the matters also may be present.

The General Counsel of the Commission, or his designee, has certified that, in his opinion, one or more of the exemptions set forth in 5 U.S.C. 552b(c)(5), (7), 9(B) and (10) and 17 CFR 200.402(a)(5), (7), 9(ii) and (10), permit consideration of the scheduled matters at the Closed Meeting.

Commissioner Walter, as duty officer, voted to consider the items listed for the Closed Meeting in a closed session.

The subject matter of the Closed Meeting scheduled for Thursday, July 16, 2009 will be:

Institution and settlement of injunctive actions; institution and settlement of administrative proceedings; other matters relating to enforcement proceedings; and opinions.

At times, changes in Commission priorities require alterations in the scheduling of meeting items.

For further information and to ascertain what, if any, matters have been added, deleted or postponed, please contact:

The Office of the Secretary at (202) 551–5400.

Dated: July 9, 2009.

Elizabeth M. Murphy,

Secretary.

[FR Doc. E9–16596 Filed 7–9–09; 11:15 am]

BILLING CODE 8010–01–P

SECURITIES AND EXCHANGE COMMISSION

Sunshine Act Meeting

Notice is hereby given, pursuant to the provisions of the Government in the Sunshine Act, Public Law 94–409, that the Securities and Exchange Commission will hold an Open Meeting on Wednesday, July 15, 2009 at 10 a.m., in the Auditorium, Room L–002.

The subject matter of the Open Meeting will be:

The Commission will consider a recommendation regarding amendments to Rule 15c2–12 (''Rule'') under the Securities Exchange Act of 1934 (''Act''), concerning the responsibilities of a broker, dealer, or municipal securities dealer acting as an underwriter in a primary offering of municipal securities and interpretive guidance intended to assist municipal securities issuers, brokers, dealers and municipal securities dealers in meeting their obligations under the antifraud provisions of the Act.

At times, changes in Commission priorities require alterations in the scheduling of meeting items.

For further information and to ascertain what, if any, matters have been added, deleted or postponed, please contact:

The Office of the Secretary at (202) 551–5400.

Dated: July 8, 2009.

Elizabeth M. Murphy,

Secretary.

[FR Doc. E9–16587 Filed 7–9–09; 11:15 am]

BILLING CODE 8010–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–60256; File No. SR–NYSEArca–2009–56]

Self-Regulatory Organizations; NYSE Arca, Inc.; Notice of Filing and Immediate Effectiveness of Proposed Rule Change To Add Two New Order Types to NYSE Arca Equities Rule 7.31

July 7, 2009.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (the ''Act'') [1] and Rule 19b–4 thereunder,[2] notice is hereby given that, on June 23, 2009, NYSE Arca, Inc. (''NYSE Arca'' or the ''Exchange'') filed with the Securities and Exchange Commission (the ''Commission'') the proposed rule change as described in Items I and II below, which Items have been prepared by the self-regulatory organization. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to add two new order types to NYSE Arca Equities Rule 7.31. A copy of this filing is available on the Exchange's Web site at *http://www.nyse.com*, at the Exchange's principal office and at the Commission's Public Reference Room.

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the self-regulatory organization included statements concerning the purpose of, and basis for, the proposed rule change and discussed any comments it received on the proposed rule change. The text of those statements may be examined at the places specified in Item IV below. The Exchange has prepared summaries, set forth in sections A, B, and C below, of the most significant parts of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

The Exchange proposes to add two new order types to NYSE Arca Equities Rule 7.31. The new order types will allow NYSE Arca Users [3] to participate at the primary listing exchange during the first 15 minutes and last 15 minutes of the trading day. For the remainder of the trading session the orders will remain in the NYSE Arca Book (''Arca Book''). The two new order types behave like a combination of currently existing order types and are discussed more thoroughly below.

Primary Until 9:45 Order

The Exchange proposes to add a new order type called the Primary Until 9:45 Order. The Primary Until 9:45 Order will permit NYSE Arca Users to submit an order that will be routed directly to the primary listing market until 9:45 a.m. (Eastern Time).[4] If the order is not executed on the primary market by 9:45 a.m. (Eastern Time), the order will be cancelled from the primary market and a new order will be entered on the Arca Book for execution during the remainder of the Exchange's Core Trading Session.[5] The Primary Until 9:45 Order may be marked with a Time in Force of Day, Good Till Cancelled (''GTC''), or Good Till Date (''GTD''). Orders that return to NYSE Arca after routing to the primary market will retain their original order attributes. Orders that return to the Arca Book at 9:45 will

[3] *See* NYSE Arca Rule 1.1(yy) for the definition of ''User.''

[4] The PO+ order was recently approved as Rule 7.31(x)(3). *See* Securities and Exchange Act Release No. 58681 (September 29, 2008); 73 FR 58285 (October 6, 2008) (order approving SR–NYSEArca–2008–90).

[5] *See* NYSE Arca Rule 7.34(a)(2) for the definition of ''Core Trading Session.''

be treated as a new order and receive a new time priority.

Currently, NYSE Arca Users can only accomplish this proposed functionality through the submission of two separate order types. First, the User would direct an order to the primary market without first sweeping the NYSE Arca Book by submitting a Primary Only (PO) or Primary Only Plus (PO+) Order.[6] [7] Then at 9:45 the User would cancel the PO or PO+ Order and submit an order to the Exchange. The Primary Until 9:45 Order will operate in a manner similar to a combination of a PO+ Order and an order that is executable on the Exchange. The Primary Until 9:45 Order simplifies this functionality into one new order type.

Primary After 3:45 Order

Similarly, the Exchange proposes to add a new order type called the Primary After 3:45 Order. The Primary After 3:45 Order will permit Exchange Users to submit an order that will remain on the Arca Book until 3:45 p.m. (Eastern Time). If the order is not executed by 3:45 p.m. (Eastern Time) the order will be cancelled from the Arca Book and entered for execution on the primary market for the remainder of the trading session. The Primary After 3:45 Order may only be marked with a Time in Force of Day, and may not be marked as GTC or GTD. Orders that route to the primary market at 3:45 will retain their original order attributes.

Currently, NYSE Arca Users can only accomplish this proposed functionality through the submission of two separate order types. First a User would submit an order for execution on the Exchange. Then, at 3:45 the User would cancel the order resting in the Arca Book and submit a PO or PO+ Order for execution on the primary market. The Primary After 3:45 Order type will operate in a manner similar to a combination of two existing order types, but simplifies this compound functionality into one new order type.

The proposed order types provide Users the ability to participate on the primary listing market during the two most active periods of the trading day, the fifteen minutes following the open and prior to the close. For the remainder of the trading day, the two new order types offer Users access to the Exchange's liquidity.

2. Statutory Basis

The proposed rule change is consistent with Section 6(b)[8] of the Securities Exchange Act of 1934 (the ''Exchange Act''), in general, and furthers the objectives of Section 6(b)(5)[9] in particular in that it is designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general, to protect investors and the public interest. The Exchange believes that the proposed rule changes are designed to accomplish these ends by providing Users the ability to participate on the primary listing market during the most active periods of the trading day.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

No written comments were solicited or received with respect to the proposed rule change.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Because the foregoing proposed rule change: (i) Does not significantly affect the protection of investors or the public interest; (ii) does not impose any significant burden on competition; and (iii) by its terms, does not become operative for 30 days from the date on which it was filed, or such shorter time as the Commission may designate, if consistent with the protection of investors and the public interest, it has become effective pursuant to Section 19(b)(3)(A) of the Act[10] and Rule 19b–4(f)(6) thereunder.[11]

A proposed rule change filed under Rule 19b–4(f)(6) normally may not become operative prior to 30 days after the date of filing.[12] However, Rule 19b–4(f)(6)(iii)[13] permits the Commission to designate a shorter time if such action is consistent with the protection of investors and the public interest. The Exchange has requested that the Commission waive the 30-day operative delay to allow market participants on NYSE Arca increased flexibility to participate on the primary listing exchange during the 15 minutes following the open and prior to the close. In addition, the waiver of the operative delay would allow the proposal to become operative on the date of approval of SR–NYSE–2009–58. The Commission believes such waiver is consistent with the protection of investors and the public interest.[14] Accordingly, the Commission designates the proposed rule change operative on July 7, 2009.[15]

At any time within 60 days of the filing of the proposed rule change, the Commission may summarily abrogate such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an e-mail to *rule-comments@sec.gov.* Please include File

[6] A PO Order will only participate in the primary market opening or re-opening. A PO+ Order will participate at any time other than the primary market opening or re-opening.

[7] PO+ Orders are routed to the primary market via the Exchange's outbound routing facility, Archipelago Securities, LLC (''Arca Securities''), a registered broker dealer. Arca Securities is an affiliated member of the NYSE, NYSE Arca, and NYSE Amex, LLC. As a result, each of these three exchanges have established certain mechanisms designed to address potential conflicts of interest regarding affiliated members generally, and Arca Securities in particular. See Securities and Exchange Act Release No. 58680 (September 29, 2008), 73 FR 58283 (October 6, 2008) (order approving SR–NYSE–2008–76); see also, Securities Exchange Act Release No. 58681 (September 29, 2008), 73 FR 58285 (October 6, 2008) (order approving NYSEArca–2008–90); see also, Securities Exchange Act Release No. 58705 (October 1, 2008), 73 FR 58995 (October 8, 2008) (order approving SR–AMEX–2008–62).

[8] 15 U.S.C. 78f(b).

[9] 15 U.S.C. 78f(b)(5).

[10] 15 U.S.C. 78s(b)(3)(A).

[11] 17 CFR 240.19b–4(f)(6).

[12] 17 CFR 240.19b–4(f)(6). In addition, Rule 19b–4(f)(6)(iii) requires a self-regulatory organization to give the Commission written notice of its intent to file the proposed rule change at least five business days prior to the date of filing of the proposed rule change, or such shorter time as designated by the Commission. The Exchange has complied with this requirement.

[13] *Id.*

[14] For purposes only of waiving the 30-day operative delay of this proposal, the Commission has considered the proposed rule's impact on efficiency, competition, and capital formation. *See* 15 U.S.C. 78c(f).

[15] Securities Exchange Act Release No. 60255 (July 7, 2009) (SR–NYSE–2009–58).

Number SR–NYSEArca–2009–56 on the subject line.

Paper Comments

• Send paper comments in triplicate to Elizabeth M. Murphy, Secretary, Securities and Exchange Commission, 100 F Street, NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–NYSEArca–2009–56. This file number should be included on the subject line if e-mail is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Room on official business days between the hours of 10 a.m. and 3 p.m. Copies of such filing also will be available for inspection and copying at the principal office of the Exchange. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–NYSEArca–2009–56 and should be submitted on or before August 3, 2009.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[16]

Elizabeth M. Murphy,

Secretary.

[FR Doc. E9–16579 Filed 7–10–09; 8:45 am]

BILLING CODE 8010–01–P

[16] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–60254; File No. SR–CBOE–2009–042]

Self-Regulatory Organizations; Chicago Board Options Exchange, Incorporated; Notice of Filing and Immediate Effectiveness of Proposed Rule Change Relating to Temporary Membership Status and Interim Trading Permit Access Fees

July 7, 2009.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Act''),[1] notice is hereby given that on June 30, 2009, the Chicago Board Options Exchange, Incorporated (''CBOE'' or the ''Exchange'') filed with the Securities and Exchange Commission (''Commission'') the proposed rule change as described in Items I, II, and III below, which Items have been prepared by the CBOE. The Commission is publishing this notice to solicit comments on the proposed rule change from interested parties.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

CBOE proposes to adjust (i) the monthly access fee for persons granted temporary CBOE membership status (''Temporary Members'') pursuant to Interpretation and Policy .02 under CBOE Rule 3.19 (''Rule 3.19.02'') and (ii) the monthly access fee for Interim Trading Permit (''ITP'') holders under CBOE Rule 3.27. The text of the proposed rule change is available on the Exchange's Web site (*http://www.cboe.org/Legal/*), at the Exchange's Office of the Secretary, and at the Commission's Public Reference Room.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, CBOE included statements concerning the purpose of, and basis for, the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The CBOE has prepared summaries, set forth in Sections A, B, and C below, of the most significant aspects of such statements.

[1] 15 U.S.C. 78s(b)(1).

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

The current access fee for Temporary Members under Rule 3.19.02[2] and the current access fee for ITP holders under Rule 3.27[3] are both $10,171 per month. Both access fees are currently set at the indicative lease rate (as defined below) for June 2009. The Exchange proposes to adjust both access fees effective at the beginning of July 2009 to be equal to the indicative lease rate for July 2009 (which is $11,552). Specifically, the Exchange proposes to revise both the Temporary Member access fee and the ITP access fee to be $11,552 per month commencing on July 1, 2009.

The indicative lease rate is defined under Rule 3.27(b) as the highest clearing firm floating monthly rate[4] of the CBOE Clearing Members that assist in facilitating at least 10% of the CBOE transferable membership leases.[5] The Exchange determined the indicative lease rate for July 2009 by polling each of these Clearing Members and obtaining the clearing firm floating monthly rate designated by each of these Clearing Members for that month.

The Exchange used the same process to set the proposed Temporary Member and ITP access fees that it used to set the current Temporary Member and ITP access fees. The only difference is that the Exchange used clearing firm floating monthly rate information for the month of July 2009 to set the proposed access fees (instead of clearing firm floating monthly rate information for the month of June 2009 as was used to set the current access fees) in order to take into account changes in clearing firm floating monthly rates for the month of July 2009.

The Exchange believes that the process used to set the proposed Temporary Member access fee and the

[2] *See* Securities Exchange Act Release No. 56458 (September 18, 2007), 72 FR 54309 (September 24, 2007) (SR–CBOE–2007–107) for a description of the Temporary Membership status under Rule 3.19.02.

[3] *See* Securities Exchange Act Release No. 58178 (July 17, 2008), 73 FR 42634 (July 22, 2008) (SR–CBOE–2008–40) for a description of the Interim Trading Permits under Rule 3.27.

[4] Rule 3.27(b) defines the clearing firm floating monthly rate as the floating monthly rate that a Clearing Member designates, in connection with transferable membership leases that the Clearing Member assisted in facilitating, for leases that utilize that monthly rate.

[5] The concepts of an indicative lease rate and of a clearing firm floating month rate were previously utilized in the CBOE rule filings that set and adjusted the Temporary Member access fee. Both concepts are also codified in Rule 3.27(b) in relation to ITPs.

proposed Temporary Member access fee itself are appropriate for the same reasons set forth in CBOE rule filing SR–CBOE–2008–12 with respect to the original Temporary Member access fee.[6] Similarly, the Exchange believes that the process used to set the proposed ITP access fee and the proposed ITP access fee itself are appropriate for the same reasons set forth in CBOE rule filing SR–CBOE–2008–77 with respect to the original ITP access fee.[7]

Each of the proposed access fees will remain in effect until such time either that the Exchange submits a further rule filing pursuant to Section 19(b)(3)(A)(ii) of the Act[8] to modify the applicable access fee or the applicable status (*i.e.*, the Temporary Membership status or the ITP status) is terminated. Accordingly, the Exchange may, and likely will, further adjust the proposed access fees in the future if the Exchange determines that it would be appropriate to do so taking into consideration lease rates for transferable CBOE memberships prevailing at that time.

The procedural provisions of the CBOE Fee Schedule related to the assessment of each proposed access fee are not proposed to be changed and will remain the same as the current procedural provisions relating to the assessment of that access fee.

2. Statutory Basis

The Exchange believes that the proposed rule change is consistent with Section 6(b) of the Act,[9] in general, and furthers the objectives of Section 6(b)(4) of the Act,[10] in particular, in that it is designed to provide for the equitable allocation of reasonable dues, fees, and other charges among persons using its facilities.

B. Self-Regulatory Organization's Statement on Burden on Competition

CBOE does not believe that the proposed rule change will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants or Others

No written comments were solicited or received with respect to the proposed rule change.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Because the foregoing rule change establishes or changes a due, fee, or other charge imposed by the Exchange, it has become effective pursuant to Section 19(b)(3)(A) of the Act[11] and subparagraph (f)(2) of Rule 19b–4[12] thereunder. At any time within 60 days of the filing of the proposed rule change, the Commission may summarily abrogate such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an e-mail to *rule-comments@sec.gov.* Please include File Number SR–CBOE–2009–042 on the subject line.

Paper Comments

- Send paper comments in triplicate to Elizabeth M. Murphy, Secretary, Securities and Exchange Commission, 100 F Street, NE., Washington DC 20549–1090.

All submissions should refer to File Number SR–CBOE–2009–042. This file number should be included on the subject line if e-mail is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Room, 100 F Street, NE., Washington, DC 20549, on official business days between the hours of 10 a.m. and 3 p.m. Copies of such filing also will be available for inspection and copying at the principal office of the Exchange. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File No. SR–CBOE–2009–042 and should be submitted on or before August 3, 2009.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[13]

Elizabeth M. Murphy,

Secretary.

[FR Doc. E9–16578 Filed 7–10–09; 8:45 am]

BILLING CODE 8010–01–P

[6] *See* Securities Exchange Act Release No. 57293 (February 8, 2008), 73 FR 8729 (February 14, 2008) (SR–CBOE–2008–12), which established the original Temporary Member access fee, for detail regarding the rationale in support of the original Temporary Member access fee and the process used to set that fee, which is also applicable to this proposed change to the Temporary Member access fee as well.

[7] *See* Securities Exchange Act Release No. 58200 (July 21, 2008), 73 FR 43805 (July 28, 2008) (SR–CBOE–2008–77), which established the original ITP access fee, for detail regarding the rationale in support of the original ITP access fee and the process used to set that fee, which is also applicable to this proposed change to the ITP access fee as well.

[8] 15 U.S.C. 78s(b)(3)(A)(ii).

[9] 15 U.S.C. 78f(b).

[10] 15 U.S.C. 78f(b)(4).

[11] 15 U.S.C. 78s(b)(3)(A).

[12] 17 CFR 240.19b–4(f)(2).

[13] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–60239; File No. SR–FINRA–2009–045]

Self-Regulatory Organizations; Financial Industry Regulatory Authority, Inc.; Notice of Filing of Proposed Rule Change Relating to Transaction-Related Charges for Trade Reporting to the OTC Reporting Facility

July 2, 2009.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Act'')[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on July 1, 2009, Financial Industry Regulatory Authority, Inc. (''FINRA'') (f/k/a National Association of Securities Dealers, Inc. (''NASD'')) filed with the Securities and Exchange Commission (''SEC'' or ''Commission'') the proposed rule change as described in Items I, II, and III below. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

FINRA is proposing to clarify the application of transaction-related charges for trade reporting to the OTC Reporting Facility (''ORF'') pursuant to FINRA Rule 7710.

The text of the proposed rule change is available on FINRA's Web site at *http://www.finra.org,* at the principal office of FINRA and at the Commission's Public Reference Room.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, FINRA included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. FINRA has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

The FINRA Rule 7700 Series, among other things, sets forth the pricing schedule for the ORF, the OTC Bulletin Board, and the Trade Reporting and Compliance Engine Services. On March 1, 2007, FINRA filed a proposed rule change (SR–NASD–2007–018) for immediate effectiveness that deleted certain fee provisions from the FINRA Rule 7700 Series [3] and amended certain other provisions.[4] In that filing, NASD Rule 7010(g) was renumbered as NASD Rule 7010, renamed, and amended to apply only to the ORF.[5] The amendments became operative on March 5, 2007.[6] As FINRA stated in the filing, the amendments made to the rule language were not intended to modify any of the charges relating to the ORF.

Although there was no intent to modify any charges in connection with reporting transactions to the ORF, the rule language, as amended by SR–NASD–2007–018, omitted some securities from the rule because of the definition of ''OTC Equity Security'' in FINRA Rule 6420. The previous rule, NASD Rule 7010(g), included a catch-all provision that applied a charge of $0.029/side to the ''reporting of all other transactions not subject to comparison.'' This language included, for example, PORTAL equity securities, which are reported to the ORF pursuant to the PORTAL rules in the FINRA Rule 6630 Series. The term ''OTC Equity Security,'' however, specifically excludes PORTAL securities and restricted securities from the definition.[7] Thus, by using the defined term ''OTC Equity Security'' from March 5, 2007, until June 17, 2009, PORTAL equity securities were inadvertently omitted from the scope of the rule language.[8]

The proposed rule change deletes the prior reference to ''OTC Equity Security'' in FINRA Rule 7710 to clarify that, from March 5, 2007, until June 17, 2009, the transaction reporting charges imposed pursuant to the rule applied to the reporting of transactions in any security, not just OTC Equity Securities, to the ORF that were not subject to comparison through the ORF.

FINRA is proposing that the operative date of the proposed rule change be retroactive from March 5, 2007, to June 17, 2009.

2. Statutory Basis

FINRA believes that the proposed rule change is consistent with the provisions of Section 15A(b)(5) of the Act,[9] which requires, among other things, that FINRA rules provide for the equitable allocation of reasonable dues, fees and other charges among members and issuers and other persons using any facility or system that FINRA operates or controls. FINRA believes that the proposed rule change clarifies the charges that were assessed with respect to transactions that were reported to the ORF from March 5, 2007, until June 17, 2009, and correctly reflects FINRA's intent when it amended the rule in SR–NASD–2007–018.

B. Self-Regulatory Organization's Statement on Burden on Competition

FINRA does not believe that the proposed rule change will result in any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

Written comments were neither solicited nor received.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Within 35 days of the date of publication of this notice in the **Federal Register** or within such longer period (i) as the Commission may designate up to 90 days of such date if it finds such longer period to be appropriate and publishes its reasons for so finding or (ii) as to which the self-regulatory organization consents, the Commission will:

(A) By order approve such proposed rule change, or

(B) Institute proceedings to determine whether the proposed rule change should be disapproved.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an e-mail to *rule-comments@sec.gov*. Please include File Number SR–FINRA–2009–045 on the subject line.

Paper Comments

- Send paper comments in triplicate to Elizabeth M. Murphy, Secretary, Securities and Exchange Commission, 100 F Street, NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–FINRA–2009–045. This file number should be included on the subject line if e-mail is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent

[3] At the time of the rule filing, the FINRA Rule 7700 Series was the NASD Rule 7000 Series. The NASD Rule 7000 Series was renumbered as the FINRA Rule 7700 Series in 2008. *See* Securities Exchange Act Release No. 58643 (September 25, 2008), 73 FR 57174 (October 1, 2008); *see also* FINRA *Regulatory Notice* 08–57 (October 2008).

[4] *See* Securities Exchange Act Release No. 55538 (March 27, 2007), 72 FR 15924 (April 3, 2007) (Notice of Filing and Immediate Effectiveness of SR–NASD–2007–018).

[5] NASD Rule 7010 was later renumbered as FINRA Rule 7710. *See* Securities Exchange Act Release No. 58643 (September 25, 2008), 73 FR 57174 (October 1, 2008).

[6] *See* Securities Exchange Act Release No. 55538 (March 27, 2007), 72 FR 15924 (April 3, 2007) (Notice of Filing and Immediate Effectiveness of SR–NASD–2007–018).

[7] *See* FINRA Rule 6420(c), (d).

[8] On June 17, 2009, FINRA filed a proposed rule change for immediate effectiveness that deleted the reference to OTC Equity Securities in the rule. *See* Securities Exchange Act Release No. 60168 (June 24, 2009), 74 FR 31471 (July 1, 2009).

[9] 15 U.S.C. 78*o*–3(b)(5).

amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Room, 100 F Street, NE., Washington, DC 20549, on official business days between the hours of 10 a.m. and 3 p.m. Copies of such filing also will be available for inspection and copying at the principal office of FINRA. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make publicly available. All submissions should refer to File Number SR–FINRA–2009–045 and should be submitted on or before August 3, 2009.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[10]

Elizabeth M. Murphy,

Secretary.

[FR Doc. E9–16448 Filed 7–10–09; 8:45 am]

BILLING CODE 8010–01–P

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–60243; File No. SR–CHX–2009–09]

Self-Regulatory Organizations; Notice of Filing and Immediate Effectiveness of a Proposed Rule Change by the Chicago Stock Exchange, Inc. Adding the Post Only and Post Only ISO Order Types

July 6, 2009.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Act'')[1], and Rule 19b–4[2] thereunder, notice is hereby given that on June 29, 2009, the Chicago Stock Exchange, Inc. (''CHX'' or the ''Exchange'') filed with the Securities and Exchange Commission (''SEC'' or ''Commission'') the proposed rule change as described in Items I and II, below, which Items have been prepared by CHX. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

CHX proposes to amend its rules to add the Post Only and Post Only ISO order types. The text of this proposed rule change is available on the Exchange's Web site at (*http://www.chx.com*), at the principal office of the Exchange, and in the Commission's Public Reference Room.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the CHX included statements concerning the purpose of and basis for the proposed rule changes and discussed any comments it received regarding the proposal. The text of these statements may be examined at the places specified in Item IV below. The CHX has prepared summaries, set forth in sections A, B and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

The Exchange proposes to amend CHX Article 20, Rule 4 to add the Post Only and Post Only ISO order types.

A Post Only Order is an order designed to encourage displayed liquidity on the Exchange. By its terms, a Post Only Order is posted on the Exchange and does not route away to another trading center. A Post Only Order will be immediately cancelled if it is marketable against a contra-side order in the Matching System when entered, or if it is at a price that would lock or cross a manual or protected quotation.

A Post Only ISO Order is a type of ISO order that will be immediately cancelled without execution if it is marketable against a contra-side order in the Matching System when entered. If a Post Only ISO is not immediately cancelled, it will be posted on the Exchange at the entered limit price. By entering a Post Only ISO, a Participant represents that such Participant has simultaneously routed one or more additional limit orders marked ''ISO,'' as necessary, to away markets to executed against the full displayed size of any protected quotation for the security with a price that is superior or equal to the limit price of the Post Only ISO entered in the Matching System. Consequently, a Post Only ISO order will be displayed by the Exchange regardless of whether it will lock or cross another market center's quote.

Orders marked Post Only and Post Only ISO will always be considered ''liquidity providing'' by the Exchange for purposes of application of the Exchange's fees and rebate programs. By making a Post Only or Post Only ISO designation, Participants are able to avoid the risk that their orders will be considered ''liquidity taking'' for purposes of application of the Exchange's fees and rebate programs. CHX notes that order types similar to the proposed Post Only and Post Only ISO order types are already in use by other market centers.[3]

2. Statutory Basis

The Exchange believes that the proposed rule change is consistent with Section 6(b) of the Act in general,[4] and furthers the objectives of Section 6(b)(5) in particular,[5] in that it is designed to promote just and equitable principles of trade, to foster cooperation and coordination with persons engaged in facilitating transaction in securities, to remove impediments and perfect the mechanisms of a free and open market, and, in general, to protect investors and the public interest by allowing CHX to amend its rules to add the Post Only and Post Only ISO order types based on similar rules already in effect at other exchanges. The addition of these order types will benefit Exchange customers and promote competition among market centers.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule change will result in any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

No written comments were either solicited or received.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Because the foregoing proposed rule change does not: (i) Significantly affect the protection of investors or the public interest; (ii) impose any significant burden on competition; and (iii) become operative for 30 days after the date of

[10] 17 CFR 200.30–3(a)(12).

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] *See* Rule 11.11(c)(5) and (c)(8)(ii) of the National Stock Exchange, Rule 11.9(c)(6) of the BATS Exchange and Rule 7.31(w) of NYSE Arca.

[4] 15 U.S.C. 78f(b).

[5] 15 U.S.C. 78f(b)(5).

the filing, or such shorter time as the Commission may designate, it has become effective pursuant to Section 19(b)(3)(A) of the Act[6] and Rule 19b–4(f)(6)[7] thereunder.

The Exchange has asked the Commission to waive the operative delay to permit the proposed rule change to become operative prior to the 30th day after filing. The Commission has determined that waiving the 30-day operative delay of the Exchange's proposal is consistent with the protection of investors and the public interest.[8] The Commission believes that the proposed rule change is substantially similar to rules adopted by other exchanges and does not raise any new regulatory issues.[9] Therefore, the Commission designates the proposal operative upon filing.

At any time within 60 days of the filing of the proposed rule change, the Commission may summarily abrogate such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an e-mail to *rule-comments@sec.gov.* Please include File Number SR–CHX–2009–09 on the subject line.

Paper Comments

- Send paper comments in triplicate to Elizabeth M. Murphy, Secretary, Securities and Exchange Commission, 100 F Street, NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–CHX–2009–09. This file number should be included on the subject line if e-mail is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Room, 100 F Street, NE., Washington, DC 20549, on official business days between the hours of 10 a.m. and 3 p.m. Copies of the filing also will be available for inspection and copying at the principal office of the Exchange. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–CHX–2009–09 and should be submitted on or before August 3, 2009.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[10]

Elizabeth M. Murphy,

Secretary.

[FR Doc. E9–16449 Filed 7–10–09; 8:45 am]

BILLING CODE 8010–01–P

[6] 15 U.S.C. 78s(b)(3)(A).

[7] 17 CFR 240.19b–4(f)(6). In addition, Rule 19b–4(f)(6) requires a self-regulatory organization to give the Commission written notice of its intent to file the proposed rule change at least five business days prior to the date of filing of the proposed rule change, or such shorter time as designated by the Commission. CHX has satisfied this requirement.

[8] For purposes only of waiving the 30-day operative delay, the Commission has considered the proposed rule's impact on efficiency, competition, and capital formation. *See* 15 U.S.C. 78c(f).

[9] *See supra* note 3.

[10] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–60247; File No. SR–BX–2009–021]

Self-Regulatory Organizations; NASDAQ OMX BX, Inc.; Order Approving Proposed Rule Change to Amend the Restated Certificate of Incorporation and By-Laws of NASDAQ OMX BX, Inc.

July 6, 2009.

On April 29, 2009, NASDAQ OMX BX, Inc. (''BX'' or ''Exchange'') filed with the Securities and Exchange Commission (''Commission'') pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Act''),[1] and Rule 19b–4 thereunder,[2] a proposed rule change to amend its Restated Certificate of Incorporation (''Certificate'') and by-laws (''By-Laws''). The proposed rule change was published for comment in the **Federal Register** on May 19, 2009.[3] The Commission received no comments regarding the proposal. This order approves the proposed rule change.

I. Description of the Proposed Rule Change

On August 29, 2008, The NASDAQ OMX Group, Inc. (''NASDAQ OMX'') acquired BX. Since then, the boards of BX and its parent company, NASDAQ OMX, have maintained their own audit committee and management compensation committee. As more fully discussed in the Notice, the Exchange states that it has found the work of these committees to overlap substantially.[4] As a result, BX proposes to revise its By-Laws to allow for the elimination of its audit and management compensation committees. In addition, BX proposes to amend its Certificate and By-Laws to reflect the name change of The Nasdaq Stock Market, Inc. to The NASDAQ OMX Group, Inc. II.

Discussion and Commission Findings

After careful review, the Commission finds that the proposed rule change is consistent with the requirements of the Act and the rules and regulations thereunder applicable to a national securities exchange.[5] In particular, the Commission finds that the proposed rule change is consistent with Section 6(b)(1) of the Act,[6] which requires a national securities exchange to be so organized and have the capacity to carry out the purposes of the Act and to comply, and to enforce compliance by its members and persons associated with its members, with the provisions of the Act. The Commission also finds that the proposed rule change is consistent with Section 6(b)(5) of the Act,[7] in that it is designed, among other things, to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general, to protect investors and the public interest. The Commission

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] *See* Securities Exchange Act Release No. 59908 (May 12, 2009), 74 FR 23459 (''Notice'').

[4] *See Notice, supra* note 3, 74 FR at 23460.

[5] In approving this proposed rule change, the Commission notes that it has considered the proposed rule's impact on efficiency, competition, and capital formation. *See* 15 U.S.C. 78c(f).

[6] 15 U.S.C. 78(b)(1).

[7] 15 U.S.C. 78f(b)(5).

previously approved a structure in which certain committees of the board of directors of NYSE Euronext, including the audit and compensation committees, were authorized to perform functions for various subsidiaries, including the New York Stock Exchange, LLC (''NYSE'').[8]

The BX Audit Committee. Currently, the BX audit committee is primarily charged with: (1) Overseeing BX's financial reporting process; (2) overseeing the systems of internal controls established by management and the BX board, as well as the legal and compliance process; (3) selection and evaluation of independent auditors; and (4) direction and oversight of the internal audit function. BX states that the NASDAQ OMX audit committee [9] will assume the duties currently performed by the BX audit committee once that committee is eliminated. The Exchange states that the responsibilities of BX's audit committee are fully duplicated by the responsibilities of the NASDAQ OMX audit committee.[10] In addition, BX states that its regulatory oversight committee has broad authority to oversee the adequacy and effectiveness of BX's regulatory and self-regulatory organization responsibilities, and therefore is able to maintain oversight over internal controls in tandem with the NASDAQ OMX audit committee. Further, BX states that the practice of NASDAQ OMX's Internal Audit Department (''Department''),[11] which performs internal audit functions for all NASDAQ OMX subsidiaries, is to report to the BX regulatory oversight committee on all internal audit matters relating to BX, which will be formally reflected in the Department's written procedures. BX also represents that, to ensure that the BX board retains authority to direct the Department's activities with respect to BX, the Department's written procedures will be amended to stipulate that the BX regulatory oversight committee may, at any time, direct the Department to conduct an audit of a matter of concern to it and report the results of the audit both to the BX regulatory oversight committee and the NASDAQ OMX audit committee.[12]

BX Management Compensation Committee. BX also proposes to eliminate its compensation committee, and to prescribe that the functions of that committee be performed by the NASDAQ OMX compensation committee or the full BX board, when required. The NASDAQ OMX By-Laws provide that its compensation committee considers and recommends compensation policies, programs, and practices for employees of NASDAQ OMX. According to BX, many employees performing work for BX are also employees of NASDAQ OMX, and certain senior officers of BX are also officers of NASDAQ OMX and other NASDAQ OMX subsidiaries because their responsibilities relate to multiple entities within the NASDAQ OMX corporate structure.[13] As a result, NASDAQ OMX establishes compensation and compensation policy for these employees.

To the extent that policies, programs, and practices must be established for any BX officers or employees who are not also NASDAQ OMX officers or employees, BX states that the BX Board will perform such actions without the use of a compensation committee, subject to recusal by Staff Directors,[14] unless the persons in question are also employees of Boston Options Exchange Regulation LLC (''BOXR'').[15]

The Commission notes that the proposed elimination of the BX audit and management compensation committees is comparable to a structure for the NYSE that the Commission previously considered and approved.[16] The Commission finds that the proposed elimination of the BX's audit and management compensation committees is consistent with the Exchange Act.

II. Conclusion

It is therefore ordered, pursuant to Section 19(b)(2) of the Act,[17] that the proposed rule change (SR–BX–2009–021) be, and it hereby is, approved.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[18]

Elizabeth M. Murphy,

Secretary.

[FR Doc. E9–16450 Filed 7–10–09; 8:45 am]

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SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–60196; File No. SR–DTC–2006–16]

Self-Regulatory Organizations; The Depository Trust Company; Order Granting Approval of a Proposed Rule Change as Amended Relating to FAST and DRS Limited Participant Requirements for Transfer Agents

June 30, 2009.

I. Introduction

On October 12, 2006, The Depository Trust Company (''DTC'') filed with the Securities and Exchange Commission (''Commission'') proposed rule change SR–DTC–2006–16 pursuant to Section 19(b)(1) of the Securities Exchange Act

[8] Securities Exchange Act Release No. 55293 (February 14, 2007), 72 FR 8033 (February 22, 2007) (SR–NYSE–2006–120).

[9] The NASDAQ OMX audit committee is composed of four or five directors, all of whom must be independent under the standards established by Section 10A(m) of the Act and the listing rules of The NASDAQ Stock Market LLC. All committee members must be able to read and understand financial statements, and at least one member must have past employment experience in finance or accounting, requisite professional certification in accounting, or any other comparable experience or background that results in the individual's financial sophistication.

[10] Specifically, BX states that: the NASDAQ OMX audit committee has broad authority to review the financial information that will be provided to shareholders and others, systems of internal controls, and audit, financial reporting and legal and compliance processes and, because NASDAQ OMX's financial statements are prepared on a consolidated basis that includes the financial results of NASDAQ OMX's subsidiaries, including BX, the NASDAQ OMX audit committee's purview necessarily includes these subsidiaries. In addition, BX states that the NASDAQ OMX audit committee currently is charged with providing oversight over financial reporting and independent auditor selection for NASDAQ OMX and all of its subsidiaries, including BX, and the NASDAQ OMX audit committee has general responsibility for oversight over internal controls and direction and oversight over the internal audit function for NASDAQ OMX and all of its subsidiaries. *See* Notice, 74 FR at 23460.

[11] *See* Notice, 74 FR at 23460–61.

[12] *See* Notice, 74 FR at 23461.

[13] *Id.*

[14] *See* BX By-Laws Article I(t). Staff Directors are directors of BX that are also serving as officers. Because the BX board would not be responsible for setting the compensation of any Staff Directors who are also officers of NASDAQ OMX, these directors would be permitted to participate in discussions concerning compensation of BX employees, but BX states that they must recuse themselves from a vote on the subject to allow the determination to be made by directors that are not officers or employees of BX. BX also states that, if a Staff Director is not also an employee of NASDAQ OMX, that Staff Director must also absent himself or herself from any deliberations regarding his or her compensation.

[15] BOXR is the subsidiary of BX that has been delegated responsibility to regulate the market operated by Boston Options Exchange Group LLC (''BOX''), an options exchange that is a facility of BX but in which neither BX nor any of its affiliates has a financial interest. Section 17 of the By-Laws of BOXR (which are part of its Limited Liability Company Agreement) provides that the compensation of BOXR's officers shall be determined by the BOXR Board. Because of BOXR's special status as a regulatory subsidiary, this provision will remain operative following the implementation of the rule change proposed by this filing. The Commission notes that, under the By-Laws, BX's regulatory oversight committee must be informed about the compensation and promotion or termination of the BX chief regulatory officer and the reasons therefor, to allow it to provide oversight over decisions affecting this key officer. *See* BX By-Laws Section 4.13(e).

[16] *See supra* note 8.

[17] 15 U.S.C. 78s(b)(2).

[18] 17 CFR 200.30–3(a)(12).

of 1934 (''Act'').[1] On March 29, 2007, and May 3, 2007, DTC filed amendments to the proposed rule change. On May 25, 2007, the Commission published notice of the proposed rule change as amended by Amendment 1 and Amendment 2.[2] On December 31, 2007, DTC again filed an amendment. Notice of the amended proposal was published in the **Federal Register** on February 20, 2007.[3] On June 23, 2008, DTC again filed an amendment. Notice of the amended proposed rule change was published in the **Federal Register** on June 19, 2008.[4] The Commission received 47 comment letters in total to the proposed rule change.[5] For the reasons discussed below, the Commission is granting approval of the proposed rule change, as amended.

II. Description

Prior to the establishment of DTC's Fast Automated Securities Transfer program (''FAST''), transfers of securities to or from DTC on behalf of its participants occurred by sending securities certificates back and forth between DTC and transfer agents. In the case of securities being deposited with DTC, DTC sent the certificates received by its participants to the transfer agent for registration into the name of DTC's nominee, Cede & Co., and the transfer agent returned the reregistered certificates to DTC. In the case of securities being withdrawn from DTC, DTC sent the certificates registered in the name of Cede & Co. to the transfer agent for reregistration into the name designated by the withdrawing participant, and the transfer agent returned a reregistered security certificate to DTC for delivery to the withdrawing participant or delivered the reregistered security certificate to another entity as directed and sent a security certificate to DTC representing the remainder of DTC's position. The process of physically transporting securities certificates between DTC and transfer agents exposed DTC, its participants, and the transfer agents to the risk of loss during transit and resulted in significant expenses.

DTC's FAST program was designed to eliminate some of the risks and costs related to this production and transportation of securities certificates. Under the FAST program, transfer agents hold FAST eligible securities in the name of Cede & Co. for the benefit of DTC.[6] As additional securities are deposited or withdrawn from DTC, transfer agents adjust the size of DTC's position as appropriate and electronically confirm theses changes with DTC. Transfer agents acting as ''FAST agents'' are holding in custody for DTC those securities that would otherwise be held at DTC. As such, the FAST program reduces the movement of certificates between DTC and the transfer agents and therefore reduces the costs and risks associated with the creation, movement, and storing of certificates for issuers, transfer agents, broker-dealers, and DTC.

The FAST program has grown substantially since first being introduced in 1975.[7] Recently all the major securities exchanges have made changes to the listing requirements to require companies to make their securities eligible to participate in the Direct Registration System (''DRS'').[8] Because FAST eligibility is a prerequisite to an issue being eligible for DRS, DTC expects that the number of FAST eligible securities will continue to expand.[9] Furthermore, because being a FAST agent is a criterion for a transfer agent's eligibility for participation in DRS, DTC anticipates significant growth in the number of FAST agents.[10]

As a result of discussions with industry representatives, including transfer agents, broker-dealers, issuers, insurance companies, and various industry associations, DTC amended its filing four times in order to address concerns with the various proposals. The provisions contained in DTC's proposed rule change, as amended by the four amendments, are the provisions discussed in this order.

(1) Amendments to DTC's FAST Requirements

Despite the FAST program's robust past growth and expected future growth, the transfer agent eligibility requirements for FAST have not substantially changed since the implementation of FAST in 1975 and do not: (i) Take into account the increased volume and value of securities processed by the transfer agents, (ii) reflect improved technology and currently available safeguards that could enhance the safekeeping of securities held by the transfer agents on behalf of DTC, and (iii) require the use of standardized audit reports addressing transfer agents' processes and controls.

In light of the FAST program's growth, DTC re-examined the transfer agent eligibility requirements of the FAST program with a view toward ensuring that DTC's assets in the custody of transfer agents, which ultimately belong to DTC's participants and their customers, are adequately protected. As more fully described below, DTC has identified aspects of these FAST eligibility requirements that need revising or additional components. The revisions and additional requirements include: (i) Insurance requirements that take into account the level of transaction volumes of securities processed by transfer agents, (ii) safekeeping requirements to clarify and to enhance security and fire protection standards and to take into consideration technological advances that allow for economical security improvements, and (iii) bookkeeping requirements to ensure compliance with applicable laws and regulations and

[1] 15 U.S.C. 78s(b)(1).

[2] Securities Exchange Act Release No. 55816 (May 25, 2007), 71 FR 30648 (June 1, 2007).

[3] Securities Exchange Act Release No. 57362 (February 20, 2008), 73 FR 10849 (February 28, 2008).

[4] Securities Exchange Act Release No. 57959 (June 12, 2008), 73 FR 57959 (June 19, 2008).

[5] *Infra* note 22. The comment letters can be found at *http://www.sec.gov/comments/sr-dtc-2006-16/dtc200616shtml.*

[6] For a description of DTC's current rules relating to FAST, refer to Securities Exchange Act Release Nos. 13342 (March 8, 1977) [File No. SR–DTC–76–3]; 14997 (July 26, 1978) [File No. SR–DTC–78–11]; 21401 (October 16, 1984) [File No. SR–DTC–84–8]; 31941 (March 3, 1993) [SR–DTC–92–15]; and 46956 (December 6, 2002) [File No. SR–DTC–2002–15].

[7] DTC introduced the FAST program in 1975 with 400 issues and 10 agents. Currently, there are over 930,000 issues and approximately 90 agents in FAST.

[8] DRS provides an investor with the ability to register her securities in her own name on the issuer's records and to efficiently transfer by book-entry movements her securities positions to her broker-dealer rather than holding a physical certificate or holding indirectly through a financial intermediary (*e.g.,* a broker-dealer) in ''street name.'' DRS also allows for the transfer of a DRS position from the books of the issuer to the account of a DTC broker-dealer participant and vice versa through the facilities of DTC using FAST.

[9] Securities Exchange Act Release Nos. 54289 (August 8, 2006), 71 FR 47278 (August 16, 2006) [File No. SR–NYSE–2006–29]; 54290 (August 8, 2006), 71 FR 47262 (August 16, 2006) [File No. SR–Amex–2006–40]; 54288 (August 8, 2006), 71 FR 47276 (August 16, 2006) [File No. SR–NASDAQ–2006–08]; 54410 (September 7, 2006), 71 FR 54316 (September 14, 2006) [File No. SR–NYSE Arca–2006–31]; 55482 (March 15, 2007), 72 FR 13547 (March 22, 2007) [File No. SR–Phlx–2006–69]; 55481 (March 15, 2007), 72 FR 13546 (March 22, 2007) [File No. SR–CHX–2006–33]; and 55480 (March 15, 2007), 72 FR 13544 (March 22, 2007) [File No. SR–BSE–2006–46].

[10] For a description of DTC's rules relating to DRS, see Securities Exchange Act Release Nos. 37931 (November 7, 1996) [File No. SR–DTC–96–15]; 41862 (September 10, 1999) [File No. SR–DTC–99–16]; 42366 (January 28, 2000) [File No. SR–DTC–00–01]; 42704 (April 19, 2000) [File No. SR–DTC–00–04]; 43586 (November 17, 2000) [File No. SR–DTC–00–09]; 44969 (August 14, 2001) [File No. SR–DTC–2001–07]; 45232 (January 3, 2002) [SR–DTC–2001–18]; 45430 (February 11, 2002) [File No. SR–DTC–2002–01]; 48885 (December 5, 2003) [File No. SR–DTC–2002–17]; and 52422 (September 14, 2005) [File No. SR–DTC–2005–11].

standardized audit reports addressing transfer agents' processes and controls.

DTC is therefore amending and restating the minimum requirements for transfer agents' participation in the FAST program in order to improve the safekeeping of securities that transfer agents hold for DTC and to provide improved safekeeping requirements as more transfer agents participate in the immobilization and dematerialization of securities. DTC's revised minimum requirements are as follows.

1. The transfer agent must be registered with the Commission or its appropriate regulatory authority, except where the transfer agent's participation in the FAST program is limited to acting solely for municipal issues or unlisted corporate debt issues (transfer agents must provide DTC with evidence of such limited use), and must follow all applicable rules under the Exchange Act and all other applicable Federal and State laws, rules, and regulations applicable to transfer agents, including OFAC regulations.

2. The transfer agent must execute and fulfill the requirements of the appropriate form of ''Balance Certificate Agreement'' [11] with DTC.[12]

3. The transfer agent must sign and fulfill requirements of the ''Operational Criteria for the FAST Transfer Agent Processing'' [13] and must comply with all applicable provisions of DTC's ''Operational Arrangements'' (''OA''),[14] as amended from time to time.[15]

4. In order to provide for the operational proficiency and efficiency of the program, the transfer agent must complete DTC's training on FAST functionality on being accepted as a FAST transfer agent.

5. In order to protect against the risk of loss, the transfer agent must carry and provide evidence to DTC of a minimum of the following standard form Financial Institution Bond or a commercial crime policy providing similar coverage in proportion to transaction volume the agent processes, as follows:

a. $10 million for a transfer agent with 25,000 or fewer transfer transactions per year as reported to the Commission;

b. $25 million for a transfer agent with over 25,000 transfer transactions per year as reported to the Commission; and

c. In addition, the transfer agent must carry and provide evidence to DTC of a minimum of $1 million in Errors and Omissions insurance.

In the event that a transfer agent can demonstrate to DTC that its existing coverage and/or capitalization would provide similar protections to DTC as the requirements set forth above, it may apply to DTC for a waiver. DTC shall have sole discretion as to whether or not to grant any such waiver.

6. In order to facilitate consistent protection against losses relating to securities in the transfer agent's control, the transfer agent must notify DTC as soon as practicable of notice of any actual lapse in insurance coverage or change in business practices, such as increasing volumes or other business changes, that would result in the transfer agent requiring additional insurance coverage as outlined above. Such notice shall be delivered to:

DTC, Inventory Management—1SL, 55 Water Street, New York, New York 10041.

A copy of such notice shall also be delivered to:

DTC, General Counsel's Office, 55 Water Street—22nd Floor, New York, New York 10041.

7. The transfer agent must provide proof to DTC of any new or substitute policy with respect to any required insurance within five (5) days after the entry into force of such new or substitute policy.

8. The transfer agent must establish and maintain electronic communications with DTC that enable FAST positions to be balanced on a daily schedule.

9. The transfer agent must provide to DTC on an annual basis within ten (10) business days of filing with the Commission, a copy of the Annual Study of Evaluation of Internal Accounting Control filed with the Commission pursuant to Exchange Act Rule 17Ad–13. If a transfer agent obtains a SAS–70 audit report, the transfer agent shall provide DTC with a copy of the report within ten (10) business days of the transfer agent's receipt of the report.

10. FAST agents must safeguard all the securities assets as required by Exchange Act Rule 17Ad–12 and with at a minimum the following additional DTC requirements:

a. Maintenance of a theft and fire central monitoring alarm system protecting the entire premises and

b. Maintenance of all certificates in a vault, safe, or other secure location, which is accessible only by authorized personnel.

11. Personnel with access to the vault, safe, or other secure location and the codes for the centralized monitoring system must comply with Exchange Act Rule 17f–2, which includes but is not limited to rules for fingerprinting staff that physically handle certificates.

12. Unless prohibited by applicable law, the transfer agent when applying to be a FAST agent must provide DTC with a copy of the two most recent compliance or deficiency correspondences from the Commission as well as any follow-up correspondences. In addition, unless prohibited by applicable law, the transfer agent on an ongoing basis must provide DTC with notice of any alleged material deficiencies documented by the Commission that may affect the activities of the transfer agent as a FAST Agent within five (5) business days of the transfer agent being notified of such deficiencies.[16]

13. Unless prohibited by applicable law, during regular business hours and upon advance notice, DTC reserves the right to visit and inspect, to the extent such visits and inspections pertain to DTC's securities position, the transfer agent's facilities, books, and records. DTC, however, is not obligated to conduct such visits or inspections.

14. Existing FAST agents shall have a period of six (6) months from the date of the Commission's approval of this rule filing to comply with these requirements, including the submission to DTC of a signed Balance Certificate Agreement, signed Operational Criteria, and all supporting documentation referenced herein. If an agent is not compliant with these requirements upon the expiration of such period, DTC

[11] DTC currently maintains three forms of the Balance Certificate Agreement: One for transfer agents, one for issuers acting as their own agent, and one for parties using a processing agent. DTC is consolidating these forms into a single form, as attached as Exhibit 2 to its initial filing.

[12] DTC notes that these minimum requirements incorporate by reference the Balance Certificate Agreement between the transfer agent and DTC.

[13] The ''Operational Criteria for the FAST Transfer Agent Processing'' is attached as Exhibit 2(b) to DTC's initial filing.

[14] For more information relating to DTC's OA, refer to Securities Exchange Act Release Nos. 45994 (May 29, 2002), 67 FR 39452 [File No. SR–DTC–2002–02]; 24818 (August 19, 1987), 52 FR 31833 [File No. DTC–87–10]; 25948 (July 27, 1988), 53 FR 29294 [File No. DTC–88–13]; 30625 (April 23, 1992), 57 FR 18534 [File No. DTC–92–06]; 35649 (April 26, 1995), 60 FR 21576 [File No. DTC–94–19]; and 39894 (April 21, 1998), 63 FR 23310 [File No. DTC–97–23].

[15] DTC notes that these minimum requirements incorporate by reference the ''Operational Criteria for FAST Transfer Agent Processing'' and all applicable terms in DTC's ''Operational Arrangements.''

[16] DTC agrees to establish and maintain any and all such safeguards as are necessary and appropriate to protect the confidentiality of any notices, correspondences, or reports from the Commission to the transfer agent, and any follow-up correspondences, that the transfer agent provides to DTC. DTC also agrees that any information obtained from these notices, correspondences, or reports will not be used for any reason other than the intended purposes as authorized by this order and will not be shared with any person or entity outside of DTC. DTC will also notify the Commission if these documents are required to be remitted by DTC to any other federal or state authority.

shall have the right, using its sole discretion, to terminate or to continue the transfer agent's status as a FAST agent.

15. An agent acting on behalf of a transfer agent shall have the same rights and responsibilities under these requirements as if it were the transfer agent.

(2) Amended and Restated Eligibility Requirements for DRS Limited Participants

DTC is revising the eligibility requirements for DRS Limited Participants [17] and the eligibility requirements for DRS issues to promote consistency with the FAST program requirements as well as to further ensure the soundness of the DRS system.

In order to be eligible to be a DRS Limited Participant, a transfer agent must:

1. Participate in the FAST program and abide by DTC's requirements governing participation in the FAST program;

2. Execute a DTC Limited Participant Account agreement;

3. Deliver transaction advices directly to investors relating to DRS Withdrawal-by-Transfer requests and provide DTC with a file containing the information required by DTC (which must include, among other things, the transaction delivery date) in a format and using the functionality as specified by DTC from time to time;

4. Complete DTC's training program on DRS and Profile Modification System (''Profile'') functionality;

5. Participate in the Profile surety or insurance program; [18]

6. Implement program changes related to DTC internal systems modifications within a reasonable time upon receiving notification from DTC of such modifications; and

7. Implement program changes to support and expand DRS processing capabilities as agreed to by the DRS Ad Hoc Committee.

Existing DRS Limited Participants shall have a period of six (6) months from the date of the Commission's approval of this rule filing within which they must comply with these requirements. If an agent is not compliant with these requirements upon the expiration of such period, DTC shall have the right using its sole discretion to terminate or to continue the agent's status as a DRS Limited Participant.

(3) Eligibility Requirements for DRS Issues

In order for an issue to be eligible as a DRS issue, the issue must:

1. Have a transfer agent accepted as a DTC DRS Limited Participant and

2. Be included in the FAST program.[19]

(4) DTC's Proposed Standard of Care Obligations With Respect to FAST

DTC is also clarifying the responsibilities and liabilities of FAST agents with respect to their participation in the FAST program. DTC believes that historically the Commission has left to user-governed clearing agencies the question of how to allocate losses associated with, among other things, clearing agency functions.[20] In conjunction with its approval of DTC's rule filing whereby DTC adopted a uniform standard of responsibility with respect to certain of its services, the Commission noted that while it had ''called on registered clearing agencies to undertake, by rule, to deliver all fully paid securities in their control to, or as directed by, the participant for whom the securities are held,'' in light of the fact that registered clearing agencies had demonstrated a high level of responsibility in safeguarding securities and funds, the Commission did not find that a standard of care based on a strict standard of liability was required either with respect to failures of the clearing agency or a sub-custodian.[21]

DTC notes that securities in the FAST program are held by a transfer agent and are not within the immediate custody and control of DTC. As such, DTC is adding a clarifying provision to DTC's Rule 6, a rule pertaining to DTC's standard of care as it applies to DTC participants, to make clear that DTC will not be liable to participants for the acts or omissions of FAST Agents or other third parties (including, but not limited to, any depository, custodian, sub-custodian, clearing or settlement system, transfer agent, registrar, data communication service or delivery service) unless a loss is caused directly by DTC's gross negligence, willful misconduct, or violation of federal securities laws for which there is a private right of action. In addition, DTC is making it clear that under no circumstance shall DTC be liable for the selection or acceptance of any third party as an agent of DTC, including a transfer agent participating in the FAST Program.

III. Comment Letters [22]

The Commission received a total of 47 comment letters on DTC's initial proposal and the subsequent four amendments (published in three notices for comment).[23] Specifically, the

[17] DRS Limited Participants are transfer agents that participate in DRS through DTC. They are bound to certain provisions of the DTC rules. Securities Exchange Act Release No. 37931 (November 7, 1996) [File No. SR–DTC–96–15].

[18] In DRS, instructions to transfer shares are sent by a broker-dealer that is a DTC participant or by a transfer agent that is a DRS Limited Participant through Profile. Profile provides screen based indemnification against false instructions from the party submitting the instructions through DRS. The indemnity is supported by either a surety bond or an insurance policy.

[19] An issue may not become a DRS issue if an ''out of balance'' position exists. An ''out of balance'' position occurs when DTC's records indicating Cede & Co.'s ownership position do not match the transfer agent's records indicating Cede & Co.'s ownership position.

[20] Securities Exchange Act Release Nos. 20221 (September 23, 1983) and 22940 (February 24, 1986). In this regard, DTC adopted a uniform standard with respect to certain of its procedures, or Service Guides, such that DTC is not liable for any loss incurred by a participant other than one caused directly by gross negligence or willful misconduct on the part of DTC. See Securities Exchange Act Release No. 44719 (August 17, 2001) [File No. SR–DTC–2001–01].

[21] Securities Exchange Act Release No. 22940 (February 24, 1986), 51 FR 7169 (order approving a rule change to establish a comprehensive standard of care and limitation of liability to its members).

[22] This order only addresses specific comments that relate to provisions in DTC's proposed rule change as the proposed rule change is being approved. It does not address comments on provisions that were either modified or deleted in response to comments.

[23] Letters from Loren K. Hanson, Assistant Secretary, Otter Tail Corporation (June 5, 2007); Steven D. Lucas, Director of Transfer Agent Compliance, Investors Bank & Trust Company (June 15, 2007); Walter E. Grote, Senior Vice President, Travelers Bond & Financial Products (June 19, 2007); The Surety & Fidelity Association of America (June 19, 2007); Thomas L. Montrone, President and Chief Executive Officer, Registrar and Transfer Company (June 19, 2007); Salli Marinov, President and Chief Executive Officer, First American Stock Transfer Company (June 20, 2007); Steve Nelson, President and Chairman of the Board, Continental Stock Transfer & Trust Company (June 20, 2007); Dennis Callahan, Chairman, Bank Depository User Group (June 21, 2007); Kevin Kopaunik, Fidelity Transfer Company (June 21, 2007); Jonathan Miller, President StockTrans, Inc. (June 21, 2008); Artie Retolatto, 1st Global Stock Transfer, LLC (June 21, 2007); James R. Alden, President, Shareholder Services Association (June 22, 2007); James Becker, Zions First National Bank (June 22, 2007); J. Donald Boggus, Jr., President and Chief Executive Officer, Crescent Banking Company and Crescent Bank and Trust Company (June 22, 2007); Albert Howell, Chairman, Regulatory and Clearance Committee, SIFMA Securities Operations Division, (June 22, 2007); Lennie M. Kaufman, Executive Vice President, Wells Fargo Shareowner Services (June 22, 2007); Lawrence Morillo, Chairman, Legal and Regulatory Subcommittee, SIFMA Operations Committee (June 22, 2007); J. Robert Morris, Managing Director, Valiant Trust Company (June 22, 2007); Cristeena G. Naser, Senior Counsel, Center for Securities, Trust & Investments, American Bankers Association (June 22, 2007); James R. Nielsen, Senior Vice President, U.S. Bank National Association (June 22, 2007); Charles V. Rossi, President, The Securities Transfer Association, Inc. (June 22, 2007); Steven Rothbloom, President and Chief Executive Officer, Computershare North America (June 22, 2007);

Continued

Commission received twenty-seven comment letters on DTC's original proposed rule change, as amended by Amendments 1 and 2.[24] Twenty-three of the commenters opposed some or all of the provisions in the proposed rule change while three commenters supported the proposed rule change. DTC also submitted a comment letter addressing the concerns and issues raised by the opposing commenters.

In response to commenters' concerns raised by the first two amendments to DTC's proposed rule change, DTC amended its filing for a third time. The Commission received ten comment letters to the third amendment, with eight commenters continuing to oppose the filing[25] and one commenter requesting clarification as to the application of one of the requirements of the proposed rule change to issuer transfer agents.[26] In response to the concerns raised by these nine commenters, DTC submitted a comment letter.[27] The comments set forth by those opposing the proposed rule change were for the most part the same concerns as were expressed in the comment letters submitted in response to the first notice of the first proposed rule change as amended by Amendments 1 and 2.

After approximately one and a half years of negotiations between DTC and the transfer agent community, DTC amended the proposed rule change for a fourth and final time. The Commission received ten comment letters in response to the proposed rule change as modified by Amendment 4, with nine commenters opposing some or all of the proposed rule and DTC again submitting a comment letter addressing the commenter concerns.[28] Seven of the nine commenters opposing the proposed rule change expressed their concerns in response to one or both of the prior published notices. None of the commenters opposing the proposed rule change, as amended by the fourth amendment, raised any issues that had not been raised in their prior comment letters.

The majority of the nine commenters that opposed DTC's proposed rule change, which were issuers, transfer agents, or industry associations representing issuers or transfer agents, an insurance company, an association representing insurance companies, the American Banking Association (''ABA''), the Office of Advocacy of the Small Business Administration (''SBA''), and one individual, opposed the proposed rule change for various reasons. Most of the commenters raised a number of general policy concerns such as: (1) DTC lacks the authority to impose rules on transfer agents, and the imposition of such rules is inappropriate given the commercial relationship between transfer agents and DTC; (2) the specific requirements are unduly burdensome, unnecessary, costly (particularly with respect to small transfer agents), and without sufficient justification; (3) the proposed rule change appears based on the premise that transfer agents act as custodian for DTC's securities as recorded on the records of the issuer—a premise that the transfer agents and banks reject as erroneous; and (4) many of the provisions proposed by DTC are inconsistent with the movement to a book-entry form of securities ownership.

The remaining commenters, which were predominantly industry associations representing broker-dealers, supported the proposed rule change because of their belief that DTC's proposed requirements are necessary to facilitate the continuing increase in the use of DRS, which they contend is necessary in order to achieve the industry's objective of decreasing or eliminating the use of securities certificates in the U.S. market, and to reduce the risks associated with the continuing increase in volume and value of DRS transactions.

The following describes commenters' concerns with the specific provisions remaining in DTC's proposed rule

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William Speirs, President, Securities Transfer Association of Canada (June 26, 2007); Susanne Trimbath, PhD, Chief Executive Officer and Chief Economist, STP Advisory Services, LLC (June 26, 2007); Thomas M. Sullivan, Chief Counsel for Advocacy, and Charles A. Maresca, Director, Interagency Affairs, U.S. Small Business Administration (June 27, 2007); Gary N. Nazare, Managing Director, Transfer Agency Services, The Bank of New York (June 29, 2007), Charles Douglas Bethill, Thacher, Proffitt & Wood LLP (December 28, 2007), Charles V. Rossi, President, Securities Transfer Association, Inc. (March 17, 2008); William Speirs, President, Securities Transfer Association of Canada (March 18, 2008); Steven G. Nelson, Chairman of the Board and President, Continental Stock Transfer & Trust Company (March 19, 2008); Martin J. McHale Jr., President, US Equity Services, Computershare (March 20, 2008); Loren Hanson, Assistant Secretary, Otter Tail Corporation (March 20, 2008); Kevin B. Halter, Jr., President, Securities Transfer Corporation (March 20, 2008); Mary C. Fernandez, Standard Registrar and Transfer Agency, Inc. (March 20, 2008); and Cristeena G. Naser, Senior Counsel, Center for Securities, Trust & Investments, American Bankers Association (March 20, 2008).

[24] Letters from Loren K. Hanson, Assistant Secretary, Otter Tail Corporation (June 5, 2007); Steven D. Lucas, Director of Transfer Agent Compliance, Investors Bank & Trust Company (June 15, 2007); Walter E. Grote, Senior Vice President, Travelers Bond & Financial Products (June 19, 2007); The Surety & Fidelity Association of America (June 19, 2007); Thomas L. Montrone, President and Chief Executive Officer, Registrar and Transfer Company (June 19, 2007); Salli Marinov, President and Chief Executive Officer, First American Stock Transfer Company (June 20, 2007); Steve Nelson, President and Chairman of the Board, Continental Stock Transfer & Trust Company (June 20, 2007); Dennis Callahan, Chairman, Bank Depository User Group (June 21, 2007); Kevin Kopaunik, Fidelity Transfer Company (June 21, 2007); Jonathan Miller, President StockTrans, Inc. (June 21, 2008); Artie Retolatto, 1st Global Stock Transfer, LLC (June 21, 2007); James R. Alden, President, Shareholder Services Association (June 22, 2007); James Becker, Zions First National Bank (June 22, 2007); J. Donald Boggus, Jr., President and Chief Executive Officer, Crescent Banking Company and Crescent Bank and Trust Company (June 22, 2007); Albert Howell, Chairman, Regulatory and Clearance Committee, SIFMA Securities Operations Division, (June 22, 2007); Lennie M. Kaufman, Executive Vice President, Wells Fargo Shareowner Services (June 22, 2007); Lawrence Morillo, Chairman, Legal and Regulatory Subcommittee, SIFMA Operations Committee (June 22, 2007); J. Robert Morris, Managing Director, Valiant Trust Company (June 22, 2007); Cristeena G. Naser, Senior Counsel, Center for Securities, Trust & Investments, American Bankers Association (June 22, 2007); James R. Nielsen, Senior Vice President, U.S. Bank National Association (June 22, 2007); Charles V. Rossi, President, The Securities Transfer Association, Inc. (June 22, 2007); Steven Rothbloom, President and Chief Executive Officer, Computershare North America (June 22, 2007); William Speirs, President, Securities Transfer Association of Canada (June 26, 2007); Susanne Trimbath, PhD, Chief Executive Officer and Chief Economist, STP Advisory Services, LLC (June 26, 2007); Thomas M. Sullivan, Chief Counsel for Advocacy, and Charles A. Maresca, Director, Interagency Affairs, U.S. Small Business Administration (June 27, 2007); Gary N. Nazare, Managing Director, Transfer Agency Services, The Bank of New York (June 29, 2007); and Charles Douglas Bethill, Thacher, Proffitt & Wood LLP (December 28, 2007).

[25] Letters from Charles V. Rossi, President, Securities Transfer Association, Inc. (March 17, 2008); William Speirs, President, Securities Transfer Association of Canada (March 18, 2008); Steven G. Nelson, Chairman of the Board and President, Continental Stock Transfer & Trust Company (March 19, 2008); Martin J. McHale Jr., President, US Equity Services, Computershare (March 20, 2008); Loren Hanson, Assistant Secretary, Otter Tail Corporation (March 20, 2008); Kevin B. Halter, Jr., President, Securities Transfer Corporation (March 20, 2008); Mary C. Fernandez, Standard Registrar and Transfer Agency, Inc. (March 20, 2008); and Cristeena G. Naser, Senior Counsel, Center for Securities, Trust & Investments, American Bankers Association (March 20, 2008).

[26] Letter from Ray Dunn, Director of Shareholder Services, The Southern Company (March 20, 2008).

[27] Letter from Charles Douglas Bethill, Thacher Proffitt & Wood, LLP (on behalf of DTC) (April 10, 2008).

[28] Letters from Martin J. McHale, President, U.S. Equity Services, Computershare (July 2, 2008); Loren Hanson, Assistant Secretary, Otter Tail Corporation (July 7, 2008); Charles V. Rossi, President, The Securities Transfer Association, Inc. (July 9, 2008); Kevin Kopaunik, Fidelity Transfer Company (July 10, 2008); Dorothy Miller, Vice President & Trust Officer, Hancock Bank (July 10, 2008); Stephen G. Nelson, President and Chairman of the Board, Continental Stock Transfer & Trust Company (July 10, 2008); William Speirs, President, Securities Transfer Association of Canada (July 11, 2008); Barbara J. Trivedi, Shareholder Services Manager, Crescent Banking Company, Crescent Bank and Trust Company (July 10, 2008); Edward L. Pittman, Thelen Reid Brown Raysman & Steiner LLP (July 15, 2008); John Petrofsky, Associate Counsel, DTC (July 30, 2008).

change in its final form after all amendments.

Jurisdiction. Many of the commenters who are transfer agents or organizations representing transfer agents oppose the proposed rule change because they contend that the Commission and banking regulators are statutorily charged with the responsibility of regulating transfer agents, and DTC is not. They further argue that even though the transfer agents are ''limited participants'' of DTC with respect to their participation in DRS, transfer agents do not have the full procedural safeguards that statutorily exist for DTC participants pursuant to Section 17A of the Exchange Act.[29] The transfer agents are also concerned that the rule change gives DTC ''unfettered'' discretion to decide which transfer agents are eligible to participate in DRS, to impose significant requirements to change transfer agent systems and operations, and to terminate transfer agents as FAST agents and limited participants at DTC's discretion.

Insurance Requirements. Almost all of those opposed to DTC's rule filing objected to some or all of DTC's proposed insurance requirements as being too costly and too onerous, particularly the ''excessively'' high minimum coverage levels, ''excessively'' low deductibles, and opposed the requirement of notifying DTC of changes in their insurance policies. The STA and several other commenters stated that they believe DTC and other registered holders have sustained virtually no economic losses as a result of under-insured transfer agent activity, thereby making the proposed insurance requirements unnecessary, overly broad, and without justification.

Many of the commenters that oppose the rule change contend that for some smaller transfer agents, the amounts of proposed minimum insurance coverage would exceed the value of DTC's securities held by the transfer agent and therefore are not reasonable. One commenter representing a large number of commercial bank and non-bank transfer agents noted that it believes that none of its members currently meet the insurance and deductible requirements.[30] In addition, this commenter along with the ABA and several other transfer agents opposed the requirement for transfer agents to (1) notify DTC at least 30 days prior to any expiration or change in insurance limits as unrealistic due to the manner in which policies are renewed, and (2) notify DTC within five days of any notice of threatened or actual lapse in coverage as an unreasonable burden on insurance carriers.

Safekeeping Requirements. Most transfer agents that opposed the amended proposed rule change took issue with DTC dictating specific physical security standards with respect to transfer agents' safeguarding obligations. Many of these commenters suggested that the Commission's safekeeping rule, Rule 17Ad–12, is sufficient to govern transfer agent safeguarding obligations.

DTC maintains that specific physical security standards are justified in light of transfer agents holding blank securities certificates, which can and have been fraudulently issued or endorsed.

Audit Requirements. Almost all the commenters opposing the proposed rule change objected to some or all of DTC's proposed audit requirements. Most of the transfer agents and industry associations representing issuers and agents argued that requiring submission to DTC of a SAS 70 or SSAE–19 report certifying compliance with DTC requirements and Commission rules and requiring attesting to the soundness of the transfer agent's controls is superfluous, unwarranted, and costly, especially in light of the requirement that an audit report be filed with the Commission by registered transfer agents pursuant to Exchange Act Rule 17Ad–13. The transfer agents contended that the existing Commission regulations should be sufficient to satisfy DTC's concerns.

One issuer acting as its own transfer agent stated its belief that DTC rules have been developed to address large commercial transfer agent operations without taking into consideration other types of transfer agents. This commenter noted that pursuant to an exemption provided to small transfer agents under Commission Rule 17Ad–4, it is exempted from the Commission's audit requirements. This commenter stated that small transfer agents pose significantly less risk to the public than large commercial transfer agents, thereby providing the basis for the Commission's exemption. This comment also argued that as a publicly traded company, it has audit requirements, including internal controls that are audited internally and externally pursuant to federal regulation. Compliance with DTC's rules, this transfer agent estimated, would cost in excess of $10,000 per year for the audit when it conducts less than 1,000 transfers per year.

Shareholder Statements. Many transfer agents objected to DTC requiring that for DRS withdrawal-by-transfers, DRS Limited Participants send a transaction advice to shareholders by mail and to DTC by electronic file. While the concept of sending such statements was not objectionable to most of the transfer agents opposing this requirement, the STA maintains that DTC has no authority to mandate notifications to shareholders holding positions in DRS.

Notice of Regulatory Action and On-site Inspection by DTC. The STA and a number of transfer agents opposed the requirement to provide DTC with copies of Commission examination reports within five business days of ''any alleged material deficiencies.'' The transfer agents contend they do not provide this information to any other registered securityholder, DTC has failed to demonstrate a need for such information, and DTC is not entitled to this confidential information under applicable law or regulation. They also objected to the requirement that transfer agents allow DTC access to their premises for on-site inspections.

System Modifications and Enhanced DRS Processing Capabilities. The STA and a number of transfer agents objected to DTC requiring transfer agents to implement program changes and system modifications to support and expand DRS processing capabilities. The transfer agents contend that such a requirement fails to address the reasonableness and necessity of any changes and fails to address the costs that may be incurred by transfer agents. Transfer agents objected to DTC unilaterally determining what changes to make to FAST and DRS without agreement from the transfer agents. They also objected to the use of the DRS Ad Hoc Committee as the ultimate arbiter of disputes because they believe the Committee is dominated by DTC and its participants and because the Committee has no governing by-laws or rules.

Compensation. The STA objected as commercially unreasonable that transfer agents provide DRS and FAST services to DTC without compensation. It argued that transfer agents should be entitled to refuse to provide DTC services if DTC refuses to pay for services rendered without the threat that DTC could throw them out of FAST and DRS.

Standard of Care. Transfer agents opposed DTC's standard of care provision because they believe that it would permit DTC to avoid responsibility for its own errors and would force transfer agents to be responsible if a third party (*i.e.,* broker-

[29] 15 U.S.C 78q–1(a)(3).

[30] Letter from the Securities Transfer Association (''STA'').

dealer or registered shareholder) were to suffer a loss caused by an error at DTC with regard to transactions or transfers involving transfer agents. They contend that the exculpatory language would force injured parties to seek recovery from the transfer agent even in the event the transfer agent were not at fault instead of each party bearing responsibility for its own processing errors. The transfer agents state that a unilateral waiver would not be in accordance with standard industry practice or public policy.

Regulatory Flexibility Act of 1980. The transfer agents contend that no evidence of any assessment has been done by DTC to examine the economic impact on small transfer agents or small issuers to ensure compliance with the requirements of the Regulatory Flexibility Act of 1980.[31]

IV. Discussion

Section 17A(b)(3)(F) of the Act requires that the rules of a clearing agency be designed to promote the prompt and accurate clearance and settlement of securities transactions, to assure the safeguarding of securities and funds which are in the custody or control of the clearing agency or for which it is responsible, to foster cooperation and coordination with persons engaged in the clearance and settlement of securities transactions, and to remove impediments to and perfect the mechanism of a national system for the prompt and accurate clearance and settlement of securities transactions, and in general, to protect investors and the public interest.[32] For the reasons described below, the Commission finds that the rule change as amended is consistent with these provisions of Section 17A.

In Section 17A of the Act, Congress set forth its finding that the prompt and accurate clearance and settlement of securities transactions, including the transfer of record ownership and safeguarding of securities and funds related to clearance and settlement activities, is necessary for the protection of investors and those acting on behalf of investors.[33] Inefficient clearance and settlement procedures, Congress found, impose unnecessary costs on investors and those acting on their behalf.[34] The Commission's approval of DTC's registration as a clearing agency constituted an important step in its efforts to facilitate the development of a national clearance and settlement system and a significant step in achieving the goals established by Congress.[35]

Consistent with this directive, the Commission has encouraged the immobilization and the dematerialization of securities holdings by supporting the use of alternatives to holding securities in certificated form in an effort to improve efficiencies and decrease risks associated with processing securities certificates.[36] Among other things, the Commission has approved the rule filings of self-regulatory organizations that require their members to use the facilities of a securities depository for the book-entry settlement of all transactions in depository-eligible securities[37] and require that before any security can be listed for trading, it must have been made depository eligible if possible.[38] The Commission has also approved a number of rule filings relating to DTC's FAST program, which has facilitated significantly more efficient processing of transfers by eliminating the physical delivery of securities certificates between transfer agents and DTC.[39] More recently the Commission has approved the implementation and expansion of DRS by approving DTC's rules relating to the administration of DRS facilities used by transfer agents and broker-dealers.[40]

DTC's FAST program authorizes transfer agents to hold securities on behalf of DTC in order to avoid having multiple physical certificates sent between transfer agents and DTC because of DTC's ever-changing ownership positions. Eliminating the need to transfer a physical certificate every time DTC's ownership position changes reduces risk and costs of processing transfers, which is a benefit to not only DTC, transfer agents, and issuers but also to the millions of beneficial owners of the securities holding in street name at DTC.

Because of the critical role the FAST and DRS programs play in the clearance and settlement of transactions in securities, which are legally owned by DTC and beneficially owned by DTC participants and their customers, the Commission believes that DTC has a legitimate interest in making sure that FAST agents and DRS Limited Participants comply with reasonable and appropriate requirements for participation in these programs in order that DTC can fulfill its statutory obligation to safeguard securities and funds that are in its custody or control or for which it is responsible. In response to the comments submitted in response to the proposed rule changes, DTC amended its proposal four times in an effort to reduce the cost and operational burden on transfer agents while still maintaining the appropriate level of safeguards necessary for DTC to comply with its statutory obligations. The Commission believes that the requirements, as amended, are fair and reasonable in light of the vital function the FAST and DRS programs play in the national clearance and settlement system and should help further improvements in the interactions between transfer agents and DTC, which is an essential component of improving the industry's dematerialization efforts.

In adopting these new rules, the Commission does not believe that DTC is attempting to ''regulate'' transfer agents as some commenters contended. Rather, the Commission believes that DTC is imposing reasonable obligations necessary for it to comply with its statutory obligations and only on those transfer agents that choose to participate in its FAST and DRS programs. Further, as a self-regulatory organization, DTC is required to file rule changes affecting the FAST or DRS program, and by extension, those transfer agents participating in these programs, with the Commission pursuant to Section

[31] The Commission notes that the Regulatory Flexibility Act of 1980 is not applicable to proposed rule changes filed by self-regulatory organizations pursuant to Section 19(b) of the Exchange Act.

[32] 15 U.S.C. 78q–1(b)(3)(F).

[33] 15 U.S.C. 78q–1(a)(1)(A).

[34] 15 U.S.C. 78q–1(a)(1)(B).

[35] Exchange Act Release No. 20221 (September 23, 1983), 48 FR 45167 (October 3, 1983).

[36] The use of certificates often results in significant delays and expenses in processing securities transactions and raises safety concerns associated with lost, stolen, and counterfeit certificates. The concerns associated with lost certificates were dramatically demonstrated during the September 11, 2001, tragedy when tens of thousand of certificates maintained in broker-dealers' vaults either were destroyed or were unavailable for transfer. See Securities Exchange Act Release No. 49405 (March 11, 2004), 69 FR 12922 (March 18, 2004) [File No. S7–13–04] (Securities Transaction Settlement Concept Release).

[37] Securities Exchange Act Release No. 32455 (June 11, 1993), 58 FR 33679 (June 18, 1993) (order approving rules requiring members, member organizations, and affiliated members of the New York Stock Exchange, National Association of Securities Dealers, American Stock Exchange, Midwest Stock Exchange, Boston Stock Exchange, Pacific Stock Exchange, and Philadelphia Stock Exchange to use the facilities of a securities depository for the book-entry settlement of all transactions in depository-eligible securities with another financial intermediary).

[38] Securities Exchange Act Release No. 35798 (June 1, 1995), 60 FR 30909 (June 12, 1995) (order approving rules setting forth depository eligibility requirements for issuers seeking to have their shares listed on the exchange).

[39] Securities Exchange Act Release Nos. 13342 (March 8, 1977) [File No. SR–DTC–76–3]; 14997 (July 26, 1978) [File No. SR–DTC–78–11]; 21401 (October 16, 1984) [File No. SR–DTC–84–8]; 31941 (March 3, 1993) [SR–DTC–92–15]; and 46956 (December 6, 2002) [File No. SR–DTC–2002–15].

[40] *See* supra note 10.

19(b) of the Exchange Act. Most of these filings have been and will continue to be filed with the Commission, published for public comment, and subject to the review and approval by the Commission. This process should provide transfer agents, as well as others affected by DTC's rules, adequate procedural safeguards.

Some commenters contend that by allowing DTC the authority to determine which transfer agents may become a FAST transfer agent or DRS Limited Participant, DTC is also granted by extension the authority to determine which transfer agents may continue to operate a transfer agent business. The Commission does not agree. Many transfer agents act as transfer agent for publicly traded securities and are not FAST agents or DRS Limited Participants. But if a transfer agent chooses to act as transfer agent for an issuer of securities that requires it to become a FAST agent or DRS Limited Participant, then DTC has an interest and statutory responsibility to ensure that the securities held on its behalf at the transfer agent are safeguarded and that the settlement of transactions in those securities, which includes safe and efficient transfers in ownership, occurs in a prompt and accurate manner.

With regards to specific operational requirements required by DTC's rule, such as insurance requirements, physical security standards, audit requirements, and system modifications to support or enhance DRS functionality, the Commission believes that the amended rule contains standards that are appropriate and reasonably designed to achieve DTC's goal of protecting the securities held by transfer agents on DTC's behalf and on behalf of DTC's participants and the participants' customers. The Commission does not find it compelling to contend that just because DTC and other registered holders have not sustained economic losses, DTC's insurance requirements are overly broad or unjustified. The point of the rule's insurance requirement is to protect against losses before losses occur. Furthermore, if a transfer agent can demonstrate that its existing coverage or capitalization provide similar protections as the insurance required DTC, DTC has the discretion to grant a waiver from any or all of the requirement. This flexibility should provide DTC the ability to properly address situations where the required coverage is too onerous or ineffective for the type, amount, or dollar value of DTC's securities held by the transfer agent.

The Commission also finds little merit in the contention that the audit reports required by the rule are unwarranted or unnecessarily costly. The Commission believes that requiring transfer agents to provide to DTC the Annual Study of Evaluation of Internal Accounting Controls, conducted pursuant to Rule 17Ad–13, and a SAS–70 audit report, if the agent has already obtained such a report for other purposes, are reasonable in light of DTC's statutory obligations to ensure the safeguarding of its securities. These audit reports provide DTC with additional information about the adequacy of the transfer agent's operational capabilities and internal controls for the transfer of record ownership and the safeguarding of related securities and funds. This is not only relevant but material information to DTC. In addition, because DTC's rule requires that transfer agents provide DTC with documents that have already been produced by the transfer agent for other purposes and should be in the transfer agent's possession, the Commission believes that there should be little or no additional expense and relatively little extra burden on transfer agents in providing these documents to DTC.

Similarly, commenters' concerns about requiring transfer agents to provide DTC with a copy of the two most recent compliance or deficiency correspondences from the Commission and all notices of alleged material deficiencies documented by the Commission appear to be misplaced. While the Commission appreciates the sensitive nature of transfer agent examination reports and the need to ensure the confidentiality of all information contained in those reports, the Commission believes nonetheless that DTC's request for these documents is reasonable. Information contained in those reports should allow DTC to better manage any potential risks associated with the transfer agent's ability to transfer securities, maintain ownership records, or operate its business in a safe manner.

Even though some commenters objected to DTC's provision requiring transfer agents to send DTC a file indicating a transaction advice has been sent to investors for each DRS withdrawal-by-transfers, the Commission believes DTC has a valid interest in requiring notice that investors have obtained a transaction advice from transfer agents. The file required to be sent to DTC will provide confirmation that the transaction advice has been sent to the investor so that DTC can close out its pending transfer position or file (sometimes referred to as an open transfer record). If that position is not closed, then DTC's records will show that the transfer remains open and it will become an outstanding aged transfer. To avoid this, DTC is requiring transfer agents to send a notice that the transfer has been completed by sending the investor a transaction advice. This process is similar to that of the current process when a transfer agent notifies DTC that a certificate has been mailed to the investor.

Finally, the Commission believes that commenters' concerns regarding the rule's clarification of DTC's standard of care provision are unfounded. The purpose of the rule change is to clarify that DTC shall not be liable to participants for acts or omissions of any third party (including without limitation any depository, custodian, sub-custodian, clearing or settlement system, transfer agent, registrar, data communication service or delivery service). DTC's Rule 6 applies to DTC's relationship with its participants, not FAST agents. Therefore, this particular provision does not have any impact on FAST Agents that are not also participants. The provision does not shift liability from DTC to FAST Agents or absolve DTC from liability to FAST Agents.

V. Conclusion

On the basis of the foregoing, the Commission finds that the proposed rule change, as amended, is consistent with the requirements of the Act and in particular with the requirements of Section 6(b)(5) of the Act and the rules and regulations thereunder. It is therefore ordered, pursuant to Section 19(b)(2) of the Act, that the proposed rule change, as amended, (File No. SR–DTC–2006–16) be and hereby is approved.[41]

For the Commission by the Division of Trading and Markets, pursuant to delegated authority.[42]

Elizabeth M. Murphy,

Secretary.

[FR Doc. E9–16455 Filed 7–10–09; 8:45 am]

BILLING CODE 8010–01–P

[41] In approving the proposed rule change, the Commission considered the proposal's impact on efficiency, competition, and capital formation. 15 U.S.C. 78c(f).

[42] 17 CFR 200.30–3(a)(12).

[1] 15 U.S.C. 78s(b)(1).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–60248; File No. SR–NASDAQ–2009–063]

Self-Regulatory Organizations; Notice of Filing and Immediate Effectiveness of a Proposed Rule Change by The NASDAQ Stock Market LLC Relating to Permanent Approval of the Exchange's Quarterly Option Series Pilot Program

July 6, 2009.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Act'')[1], and Rule 19b–4[2] thereunder, notice is hereby given that on June 26, 2009, The NASDAQ Stock Market LLC (''Nasdaq'') filed with the Securities and Exchange Commission (''SEC'' or ''Commission'') the proposed rule change as described in Items I and II below, which Items have been prepared by Nasdaq. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

Nasdaq proposes for NOM to modify Chapter IV, Section 6 (Series of Options Contracts Open for Trading) and Chapter XIV Sec. 11 (Terms of Index Options Contracts), to make permanent the Exchange's Quarterly Option Series Pilot Program (''QOS Program''), and expand and conform the QOS Program to similar programs of other exchange.

The text of the proposed rule change is available from Nasdaq's Web site at *http://nasdaq.cchwallstreet.com*, at Nasdaq's principal office, and at the Commission's Public Reference Room.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, Nasdaq included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. Nasdaq has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

[2] 17 CFR 240.19b–4.

[3] *See* Securities Exchange Act Release No. 58209 (July 22, 2008), 73 FR 43966 (July 29, 2008) (SR–NASDAQ–2008–064) (notice of filing and immediate effectiveness establishing QOS Program as pilot through July 10, 2009).

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

The purpose of the proposed rule change is to make the QOS Program permanent, and expand and conform the QOS Program to make it similar to programs of other exchanges.

On July 22, 2008, NASDAQ filed SR–NASDAQ–2009–064 with the Commission to establish the QOS Program.[3] The QOS Program allows the Exchange to list and trade options that expire at the close of business on the last business day or a calendar quarter (''Quarterly Option Series'' or ''QOS''). Under the QOS Program, the Exchange may select up to five (5) currently listed options classes that are exchange traded fund (''ETF'') options on which Quarterly Option Series may be opened. In addition, the Exchange may also list Quarterly Option Series on any options classes that are selected by other securities exchanges that employ a similar program under their respective rules.[4]

The Exchange may list series that expire at the end of the next consecutive four (4) calendar quarters, as well as the fourth quarter of the next calendar year. All Quarterly Option Series are P.M. settled.

If an option is selected for participation in the QOS Program, the strike price of each Quarterly Option Series is fixed at a price per share, with at least two strike prices above and two strike prices below the approximate value of the underlying security at about the time the Quarterly Options Series is opened for trading on the Exchange. The Exchange will list strikes prices for a Quarterly Option series that are within $5 from the closing price of the underlying on the preceding day.

The Exchange may open for trading additional Quarterly Options Series of the same class when the Exchange deems it necessary to maintain an orderly market, to meet customer demand or when the market price of the underlying security moves substantially from the initial exercise price or prices. To the extent that any additional strike prices are listed by the Exchange, such additional strike prices shall be within thirty percent (30%) above or below the closing price of the underlying ETF on the preceding day. The Exchange may also open additional strike prices of Quarterly Option Series in ETF options that are more than 30% above or below the current price of the underlying ETF provided that demonstrated customer interest exists for such series, as expressed by institutional, corporate or individual customers or their brokers. Market-Makers trading for their own account shall not be considered when determining customer interest under this provision. The opening of the new Quarterly Options Series shall not affect the series of options of the same class previously opened. In addition to the initial listed series, the Exchange may list up to sixty (60) additional series per expiration month for each Quarterly Options Series in ETF options.[5]

The interval between strike prices on Quarterly Options Series shall be the same as the interval for strike prices for series in that same options class that expire in accordance with the normal monthly expiration cycle. By definition, Quarterly Option Series on an option class can never expire in the same week in which monthly option series on the same class expires. And, the Exchange will not list a Short Term Option Series on an options class the expiration of which coincides with that of a Quarterly Options Series on the same options class.

The Exchange has adopted a delisting policy with respect to QOS in ETF options.[6] On a monthly basis, the Exchange reviews series that are outside a range of five (5) strikes above and five (5) strikes below the current price of the underlying ETF, and delists series with no open interest in both the put and the call series having a: (i) Strike higher than the highest strike price with open interest in the put and/or call series for a given expiration month; and (ii) strike lower than the lowest strike price with open interest in the put and/or call series for a given expiration month.

[4] Proposed Chapter XIV, Section 11(g), which is similar to NASDAQ OMX PHLX, Inc. (''Phlx'') Rule 1101A(a)(v), extends the Exchange's QOS Program to Index Options (the ''Index QOS Program''). The Exchange is also proposing changes in its Chapter IV, Section 6, Supplementary Material .04 regarding P.M. settlement and eligibility of Index Options for the QOS Program, to conform the Exchange's QOS Program rules to those of other exchanges, such as, for example, Commentary .08 to Phlx Rule 1012 and CBOE Rules 5.5(e) and 24.9(a).

[5] *See* Securities Exchange Act Release No. 58209 (July 22, 2008), 73 FR 43966 (July 29, 2008) (SR–NASDAQ–2008–064).

[6] *Id.*

[4] Proposed Chapter XIV, Section 11(g), which is similar to NASDAQ OMX PHLX, Inc. (''Phlx'') Rule 1101A(a)(v), extends the Exchange's QOS Program to Index Options (the ''Index QOS Program''). The Exchange is also proposing changes in its Chapter IV, Section 6, Supplementary Material .04 regarding P.M. settlement and eligibility of Index Options for the QOS Program, to conform the Exchange's QOS Program rules to those of other exchanges, such as, for example, Commentary .08 to Phlx Rule 1012 and CBOE Rules 5.5(e) and 24.9(a).

[5] *See* Securities Exchange Act Release No. 58209

Notwithstanding the delisting policy, customer requests to add strikes and/or maintain strikes in QOS in ETF options in series eligible for delisting shall be granted.

Further, in connection with the delisting policy, if the Exchange identifies series for delisting, the Exchange shall notify other options exchanges with similar delisting policies regarding eligible series for listing, and shall work with such other exchanges to develop a uniform list of series to be delisted, so as to ensure uniform series delisting of multiply listed options classes.

The Exchange has selected the following five ETF option classes to participate in the QOS Program: DIAMONDS Trust (DIA) options, Standard and Poor's Depositary Receipts/SPDRs (SPY) options, iShares Russell 2000 Index Fund (IWM) options, PowerShares QQQ Trust (QQQQ) options and Energy Select SPDR (XLE) options. The Exchange believes the QOS Program has been successful and well received by its members and the investing public for the approximately twelve months that it has been in operation as a pilot.[7]

In support of approving the QOS Program on a permanent basis, the Exchange has submitted to the Commission a Quarterly Option Program Report (''Report'') detailing the Exchange's experience with the QOS Program.[8] Specifically, the Report contains data and written analysis regarding the five (5) ETF option classes included in the QOS Program. The Report was submitted under separate cover and seeks confidential treatment under the Freedom of Information Act.

The Exchange believes there is sufficient investor interest and demand in the QOS Program to warrant its permanent approval. The Exchange believes that, for the approximately twelve months that the QOS Program has been in operation, it has provided investors with additional means of managing their risk exposures and carrying out their investment objectives. Furthermore, the Exchange has not experienced any capacity-related problems with respect to Quarterly Option Series. The Exchange also represents that it has the necessary system capacity to continue to support the option series listed under the QOS Program.

2. Statutory Basis

The Exchange believes that its proposal is consistent with Section 6(b) of the Act[9] in general, and furthers the objectives of Section 6(b)(5) of the Act[10] in particular, in that it is designed to promote just and equitable principles of trade, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general, to protect investors and the public interest by making permanent the Exchange's Quarterly Option Series Pilot Program.

B. Self-Regulatory Organization's Statement on Burden on Competition

Nasdaq does not believe that the proposed rule change will result in any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

Written comments were neither solicited nor received.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Because the foregoing proposed rule change does not: (i) Significantly affect the protection of investors or the public interest; (ii) impose any significant burden on competition; and (iii) become operative for 30 days after the date of the filing, or such shorter time as the Commission may designate, if consistent with the protection of investors and the public interest, it has become effective pursuant to 19(b)(3)(A) of the Act[11] and Rule 19b–4(f)(6) thereunder.[12]

The Exchange has asked the Commission to waive the operative delay to permit the proposed rule change to become operative prior to the 30th day after filing so that the Exchange may immediately implement and permanently establish a Quarterly Options Series Program that is consistent with those of other options exchanges.[13] The Commission has determined that waiving the 30-day operative delay of the Exchange's proposal is consistent with the protection of investors and the public interest because such waiver will enable the Exchange to expand and conform the QOS Program to make it similar to programs of other exchanges and continue the current QOS program without disruption.[14] Therefore, the Commission designates the proposal operative upon filing.

At any time within 60 days of the filing of the proposed rule change, the Commission may summarily abrogate such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml*); or
- Send an e-mail to *rule-comments@sec.gov.* Please include File Number SR–NASDAQ–2009–063 on the subject line.

Paper Comments

- Send paper comments in triplicate to Elizabeth M. Murphy, Secretary,

[7] The Index QOS Program found in Chapter XIV, Section 11(g) is similar to the QOS Program in Chapter IV, Section 6, Supplementary Material .04, but has several differences. Principal among them are, first, that the strike price of each QOS will be fixed with at least two, but not more than five, strike prices above and two, but not more than five, strike prices below the value of the underlying security at about the time that a QOS is opened for trading on the Exchange. Second, that the exercise price of each QOS opened for trading on the Exchange shall be reasonably related to the current index value of the underlying index to which such series relates at or about the time such series of options is first opened for trading on the Exchange (the term ''reasonably related to the current index value of the underlying index'' means that the exercise price is within thirty percent (30%) of the current index value). Third, that the Exchange may open additional strike prices of QOS that are below the value of the underlying index provided that the total number of strike prices below the value of the underlying index is no more than five. And fourth, there is no delisting policy in the Index QOS Program.

[8] The requirements for the Report were recently set forth in Securities Exchange Act Release No. 58209 (July 22, 2008), 73 FR 43966 (July 29, 2008) (SR–NASDAQ–2008–064).

[9] 15 U.S.C. 78f(b).

[10] 15 U.S.C. 78f(b)(5).

[11] 15 U.S.C. 78s(b)(3)(A).

[12] 17 CFR 240.19b–4(f)(6). In addition, Rule 19b–4(f)(6) requires a self-regulatory organization to give the Commission written notice of its intent to file the proposed rule change at least five business days prior to the date of filing of the proposed rule change, or such shorter time as designated by the Commission. Nasdaq has satisfied this requirement.

[13] *See* Securities Exchange Act Release No. 60164 (June 23, 2009), 74 FR 31333 (June 30, 2009) (SR–CBOE–2009–029) (approving the quarterly options series program on a permanent basis).

[14] For purposes only of waiving the 30-day operative delay, the Commission has considered the proposed rule's impact on efficiency, competition, and capital formation. *See* 15 U.S.C. 78c(f).

Securities and Exchange Commission, 100 F Street, NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–NASDAQ–2009–063. This file number should be included on the subject line if e-mail is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Room, 100 F Street, NE., Washington, DC 20549, on official business days between the hours of 10 a.m. and 3 p.m. Copies of the filing also will be available for inspection and copying at the principal office of the Exchange. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–NASDAQ–2009–063 and should be submitted on or before August 3, 2009.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[15]

Elizabeth M. Murphy,

Secretary.

[FR Doc. E9–16451 Filed 7–10–09; 8:45 am]

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[15] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–60249; File No. SR–Phlx–2009–50]

Self-Regulatory Organizations; Notice of Filing and Immediate Effectiveness of a Proposed Rule Change by NASDAQ OMX PHLX, Inc. Relating to Permanent Approval of the Exchange's Quarterly Option Series Pilot Program

July 6, 2009.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Act'')[1], and Rule 19b–4[2] thereunder, notice is hereby given that on June 26, 2009, NASDAQ OMX PHLX, Inc. (''Phlx'' or ''Exchange'') filed with the Securities and Exchange Commission (''SEC'' or ''Commission'') the proposed rule change as described in Items I and II below, which Items have been prepared by Phlx. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Exchange proposes to amend Phlx rules to amend its Rules 1012 (Series of Options Open for Trading) and 1101A (Terms of Option Contracts), to make permanent the Exchange's Quarterly Option Series Pilot Program (''QOS Program'').

The text of the proposed rule change is available on the Exchange's Web site at *http://nasdaqomxphlx.cchwallstreet.com/NASDAQOMXPHLX/Filings/,* at the principal office of the Exchange, and at the Commission's Public Reference Room.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, Phlx included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. Phlx has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

The purpose of the proposed rule change is to make the QOS Program permanent.

On July 9, 2007, the Exchange filed SR–Phlx-2007–08 with the Commission to establish the QOS Program.[3] The QOS Program allows Phlx to list and trade options that expire at the close of business on the last business day of a calendar quarter (''Quarterly Option Series'' or ''QOS''). Under the QOS Program, Phlx may select up to five (5) currently listed option classes that are either Index Options and exchange traded fund (''ETF'') options on which Quarterly Option Series may be opened. In addition, Phlx may also list Quarterly Option Series on any options classes that are selected by other securities exchanges that employ a similar program under their respective rules.[4]

The Exchange may list series that expire at the end of the next consecutive four (4) calendar quarters, as well as the fourth quarter of the next calendar year. All Quarterly Option Series are P.M. settled.[5]

If an option is selected for participation in the QOS Program, the strike price of each Quarterly Option Series is fixed at a price per share, with at least two strike prices above and two strike prices below the approximate value of the underlying security at about the time the Quarterly Options Series is opened for trading on the Exchange. Phlx will list strikes prices for a Quarterly Option series that are within $5 from the closing price of the underlying on the preceding day.

The Exchange may open for trading additional Quarterly Options Series of the same class when the Exchange deems it necessary to maintain an orderly market, to meet customer demand or when the market price of the underlying security moves substantially from the initial exercise price or prices. To the extent that any additional strike prices are listed by the Exchange, such additional strike prices shall be within thirty percent (30%) above or below the closing price of the underlying ETF on the preceding day. The Exchange may also open additional strike prices of Quarterly Option Series in ETF options that are more than 30% above or below the current price of the underlying ETF provided that demonstrated customer interest exists for such series, as expressed by institutional, corporate or individual customers or their brokers. Market-Makers trading for their own account shall not be considered when determining customer interest under this provision. The opening of the new

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] *See* Securities Exchange Act Release No. 55301 (February 15, 2007), 72 FR 8238 (February 23, 2007) (SR–Phlx-2007–08) (notice of filing and immediate effectiveness). The QOS Program has since been extended and is currently scheduled to expire on July 10, 2009. *See* Securities Exchange Act Release No. 58039 (June 26, 2008), 73 FR 38284 (July 3, 2008) (SR–Phlx–2009–44) (notice of filing and immediate effectiveness).

[4] Rule 1101A(b)(v) extends the QOS Program to Index Options (the ''Index QOS Program'').

[5] The Exchange is making minor changes to Commentary .08 to Phlx Rule 1012 and Rule 1101A(b)(v) to conform the Exchange's rules to those of other exchanges such as, for example, CBOE Rules 5.5(e)(2) and 24.9(a)(2), regarding P.M. settlement and listing series in the fourth quarter of the next calendar year.

Quarterly Options Series shall not affect the series of options of the same class previously opened. In addition to the initial listed series, the Exchange may list up to sixty (60) additional series per expiration month for each Quarterly Options Series in ETF options.[6]

The interval between strike prices on Quarterly Options Series shall be the same as the interval for strike prices for series in that same options class that expire in accordance with the normal monthly expiration cycle. By definition, Quarterly Option Series on an option class can never expire in the same week in which monthly option series on the same class expires. And, the Exchange will not list a Short Term Option Series on an options class the expiration of which coincides with that of a Quarterly Options Series on the same options class.

The Exchange has adopted a delisting policy with respect to QOS in ETF options.[7] On a monthly basis, the Exchange reviews series that are outside a range of five (5) strikes above and five (5) strikes below the current price of the underlying ETF, and delists series with no open interest in both the put and the call series having a: (i) Strike higher than the highest strike price with open interest in the put and/or call series for a given expiration month; and (ii) strike lower than the lowest strike price with open interest in the put and/or call series for a given expiration month.

Notwithstanding the delisting policy, customer requests to add strikes and/or maintain strikes in QOS in ETF options in series eligible for delisting shall be granted.

Further, in connection with the delisting policy, if the Exchange identifies series for delisting, the Exchange shall notify other options exchanges with similar delisting policies regarding eligible series for listing, and shall work with such other exchanges to develop a uniform list of series to be delisted, so as to ensure uniform series delisting of multiply listed options classes.

During the last quarter of 2008 (and for the new expiration month added after December Quarterly Option Series expiration), the Exchange was permitted to list up to one hundred (100) additional series per expiration month for each Quarterly Options Series in ETF options.[8]

The Exchange has selected the following five ETF option classes to participate in the QOS Program: DIAMONDS Trust (DIA) options, Standard and Poor's Depositary Receipts/SPDRs (SPY) options, iShares Russell 2000 Index Fund (IWM) options, PowerShares QQQ Trust (QQQQ) options and Energy Select SPDR (XLE) options. Phlx believes the QOS Program has been successful and well received by its members and the investing public for the nearly three years that it has been in operation as a pilot.[9]

In support of approving the QOS Program on a permanent basis, the Exchange has submitted to the Commission a Quarterly Option Program Report (''Report'') detailing the Exchange's experience with the QOS Program.[10] Specifically, the Report contains data and written analysis regarding the five (5) ETF option classes included in the QOS Program. The Report was submitted under separate cover and seeks confidential treatment under the Freedom of Information Act.

The Exchange believes there is sufficient investor interest and demand in the QOS Program to warrant its permanent approval. The Exchange believes that, for the nearly three years that the QOS Program has been in operation, it has provided investors with additional means of managing their risk exposures and carrying out their investment objectives. Furthermore, the Exchange has not experienced any capacity-related problems with respect to Quarterly Option Series. The Exchange also represents that it has the necessary system capacity to continue to support the option series listed under the QOS Program.

2. Statutory Basis

The Exchange believes that its proposal is consistent with Section 6(b) of the Act[11] in general, and furthers the objectives of Section 6(b)(5) of the Act[12] in particular, in that it is designed to promote just and equitable principles of trade, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general to protect investors and the public interest, by making permanent the Exchange's Quarterly Option Series Pilot Program.

B. Self-Regulatory Organization's Statement on Burden on Competition

Phlx does not believe that the proposed rule change will result in any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

Written comments were neither solicited nor received.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Because the foregoing proposed rule change does not: (i) Significantly affect the protection of investors or the public interest; (ii) impose any significant burden on competition; and (iii) become operative for 30 days after the date of the filing, or such shorter time as the Commission may designate, if consistent with the protection of investors and the public interest, it has become effective pursuant to 19(b)(3)(A) of the Act[13] and Rule 19b–4(f)(6) thereunder.[14]

The Exchange requests that the Commission waive the 30-day operative delay so that the Exchange can permanently establish a Quarterly Options Series Program that is consistent with those of other options exchanges.[15] In addition, the Commission notes that the Exchange's QOS Program currently is scheduled to expire on July 10, 2009. The

[6] *See* Securities Exchange Act Release No. 57583 (March 31, 2008), 73 FR 18589 (April 4, 2008) (SR–Phlx–2008–23)(notice of filing and immediate effectiveness).

[7] *Id.*

[8] *See* Securities Exchange Act Release No. 58943 (November 13, 2008), 73 FR 70398 (November 20, 2008) (SR–Phlx–2008–78) (notice of filing and immediate effectiveness).

[9] The Index QOS Program found in Rule 1101A(v) is similar to the QOS Program in Rule 1012, but has several differences. Principal among them are, first, that the strike price of each QOS will be fixed with at least two, but not more than five, strike prices above and two, but not more than five, strike prices below the value of the underlying security at about the time that a QOS is opened for trading on the Exchange. Second, that the exercise price of each QOS opened for trading on the Exchange shall be reasonably related to the current index value of the underlying index to which such series relates at or about the time such series of options is first opened for trading on the Exchange (the term ''reasonably related to the current index value of the underlying index'' means that the exercise price is within thirty percent (30%) of the current index value). Third, that the Exchange may open additional strike prices of QOS that are below the value of the underlying index provided that the total number of strike prices below the value of the underlying index is no more than five. And fourth, there is no delisting policy in the Index QOS Program.

[10] The requirements for the Report were recently set forth in Securities Exchange Act Release No. 57583 (March 31, 2008), 73 FR 18589 (April 4, 2008) (SR–Phlx–2008–23).

[11] 15 U.S.C. 78f(b).

[12] 15 U.S.C. 78f(b)(5).

[13] 15 U.S.C. 78s(b)(3)(A).

[14] 17 CFR 240.19b–4(f)(6). In addition, Rule 19b–4(f)(6) requires a self-regulatory organization to give the Commission written notice of its intent to file the proposed rule change at least five business days prior to the date of filing of the proposed rule change, or such shorter time as designated by the Commission. Phlx has satisfied this requirement.

[15] *See* Securities Exchange Act Release No. 60164 (June 23, 2009), 74 FR 31333 (June 30, 2009) (SR–CBOE–2009–029) (approving the quarterly options series program on a permanent basis).

Commission therefore has determined that waiving the 30-day operative delay of the Exchange's proposal is consistent with the protection of investors and the public interest because such waiver will enable the Exchange to permanently establish the QOS program without disruption.[16] Therefore, the Commission designates the proposal operative upon filing.

At any time within 60 days of the filing of the proposed rule change, the Commission may summarily abrogate such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (*http://www.sec.gov/rules/sro.shtml);* or
- Send an e-mail to *rule-comments@sec.gov.* Please include File Number SR–Phlx-2009–50 on the subject line.

Paper Comments

- Send paper comments in triplicate to Elizabeth M. Murphy, Secretary, Securities and Exchange Commission, 100 F Street, NE., Washington, DC 20549–1090.

All submissions should refer to File Number SR–Phlx–2009–50. This file number should be included on the subject line if e-mail is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (*http://www.sec.gov/rules/sro.shtml*). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Room, 100 F Street, NE., Washington, DC 20549, on official business days between the hours of 10 a.m. and 3 p.m. Copies of the filing also will be available for inspection and copying at the principal office of the Exchange. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly. All submissions should refer to File Number SR–Phlx–2009–50 and should be submitted on or before August 3, 2009.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.[17]

Elizabeth M. Murphy,

Secretary.

[FR Doc. E9–16452 Filed 7–10–09; 8:45 am]

BILLING CODE 8010–01–P

[16] For purposes only of waiving the 30-day operative delay, the Commission has considered the proposed rule's impact on efficiency, competition, and capital formation. *See* 15 U.S.C. 78c(f).

[17] 17 CFR 200.30–3(a)(12).

DEPARTMENT OF TRANSPORTATION

National Highway Traffic Safety Administration

Reports, Forms and Record Keeping Requirements; Agency Information Collection Activity Under OMB Review

AGENCY: National Highway Traffic Safety Administration, DOT.

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*), this notice announces that the Information Collection Request (ICR) abstracted below has been forwarded to the Office of Management and Budget (OMB) for review and comment. The ICR describes the nature of the information collections and their expected burden. The **Federal Register** Notice with a 60-day comment period was published on February 19, 2009 [FR Doc. 2009–0037, Vol. 74, No. 32, Pages 7737–7738].

DATES: Comments must be submitted on or before August 12, 2009.

FOR FURTHER INFORMATION CONTACT: Charlene Doyle, Contracting Officer's Technical Representative, Office of Regulatory Analysis and Evaluation, National Highway Traffic Safety Administration, 1200 New Jersey Ave., SE., NVS–431, Washington, DC 20590. Ms. Doyle's phone number is 202–366–1276 and her e-mail address is *charlene.doyle@dot.gov*.

SUPPLEMENTARY INFORMATION:

National Highway Traffic Safety Administration

Title: An In-Depth Examination of Pedestrian Involved Hit and Run Traffic Crashes.

OMB Number: 2127–New.

Type of Request: Request for public comment on proposed collection of information.

Abstract: The National Highway Traffic Safety Administration (NHTSA) was established to reduce the mounting number of deaths, injuries and economic losses resulting from motor vehicle crashes on the Nation's highways. As part of this statutory mandate, NHTSA is authorized to conduct research as a foundation for the development of motor vehicle standards and traffic safety programs. Between 1998 and 2007, of the more than 48,000 pedestrian deaths recorded within the United States, over 9,000 (19 percent) were caused by hit-and-run drivers. The data collected in this survey of drivers, along with police crash and court data from 10 counties, will be used to identify areas for targeting improvements, identify scenarios in which hit-and-run collisions are more likely to occur, and assist in the selection of cost-effective countermeasures to reduce the incidence of pedestrian hit-and-run crashes.

Affected Public: Individuals.

Estimated Total Annual Burden: 855 hours.

ADDRESSES: Send comments, within 30 days, to the Office of Information and Regulatory Affairs, Office of Management and Budget, 725–17th Street, NW., Washington, DC 20503, Attention NHTSA Desk Officer.

Comments are invited on: Whether the proposed collection of information is necessary for the proper performance of the functions of the Department, including whether the information will have practical utility; the accuracy of the Department's estimate of the burden of the proposed information collection; ways to enhance the quality, utility and clarity of the information to be collected; and ways to minimize the burden of the collection of information on respondents, including the use of automated collection techniques or other forms of information technology. A comment to OMB is most effective if OMB receives it within 30 days of publication.

Authority: 44 U.S.C. 3506(c)(2)(A).

James F. Simons,

Director, Office of Regulatory Analysis and Evaluation.

[FR Doc. E9–16585 Filed 7–10–09; 8:45 am]

BILLING CODE 4910–59–P

DEPARTMENT OF TRANSPORTATION

Federal Transit Administration

[FTA Docket No. FTA–2009–0032]

Agency Information Collection Activity Under OMB Review

AGENCY: Federal Transit Administration, DOT.

ACTION: Notice of request for comments.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*), this notice announces that the Information Collection Request (ICR) abstracted below has been forwarded to the Office of Management and Budget (OMB) for approval. The **Federal Register** Notice with a 60-day comment period soliciting comments was published on April 27, 2008. No comments were received in response to that notice.

DATES: Comments must be submitted before August 12, 2009. A comment to OMB is most effective if OMB receives it within 30 days of publication.

FOR FURTHER INFORMATION CONTACT: LaStar Matthews, Office of Administration, Office of Management Planning, (202) 366–2295 or e-mail: *LaStar.Matthews@dot.gov*.

SUPPLEMENTARY INFORMATION:

Title: Transit Investments in Greenhouse Gas and Energy Reduction Program (*OMB Number: 2132–0566*).

Abstract: The American Recovery and Reinvestment Act of 2009 (ARRA) established the Transit Investments in Greenhouse Gas and Energy Reduction (TIGGER) Program. This program is a new $100,000,000 discretionary grant program to support public transit agencies in making capital investments that will assist in reducing the energy consumption or greenhouse gas emissions of their public transportation systems.

The information collected is submitted as part of the application for grants used to determine eligibility of applicants and project selection. Collection of project management information also provides documentation that the applicants and recipients are meeting program objectives and are complying with FTA Circular 5010.1D Grant Management Requirements and other federal requirements.

To meet the requirements of the American Recovery and Reinvestment Act, FTA requested an emergency approval from OMB for the Transit Investments in Greenhouse Gas and Energy Reduction Program. OMB approved FTA's emergency request for approval on March 10, 2009. The OMB Control Number is 2132–0566. FTA published a **Federal Register** Notice for Solicitation of Comments and Notice of Availability of Fiscal Year 2009 Funding for Transit Investments in Greenhouse Gas and Energy Reduction Grants on March 24, 2009.

Estimated Total Annual Burden: 32,080 hours.

ADDRESSES: All written comments must refer to the docket number that appears at the top of this document and be submitted to the Office of Information and Regulatory Affairs, Office of Management and Budget, 725—17th Street, NW., Washington, DC 20503, *Attention:* FTA Desk Officer.

Comments Are Invited On: Whether the proposed collection of information is necessary for the proper performance of the functions of the Department, including whether the information will have practical utility; the accuracy of the Department's estimate of the burden of the proposed information collection; ways to enhance the quality, utility, and clarity of the information to be collected; and ways to minimize the burden of the collection of information on respondents, including the use of automated collection techniques or other forms of information technology.

Issued: July 7, 2007.

Ann M. Linnertz,

Associate Administrator for Administration.

[FR Doc. E9–16509 Filed 7–10–09; 8:45 am]

BILLING CODE 4910–57–P

DEPARTMENT OF TRANSPORTATION

Maritime Administration

[USCG–2006–28532]

Port Dolphin Energy LLC, Port Dolphin Energy Liquefied Natural Gas Deepwater Port License Application; Final Application Public Hearing and Final Environmental Impact Statement

AGENCY: Maritime Administration, DOT.

ACTION: Notice of availability; notice of public hearing; request for comments.

SUMMARY: The Maritime Administration and the U.S. Coast Guard (USCG) announce the availability of the Final Environmental Impact Statement (FEIS) for Port Dolphin Energy LLC, Port Dolphin Energy Liquefied Natural Gas Deepwater Port license application. The application describes a project that would be located approximately 28 miles off the western coast of Florida, and approximately 42 miles from Port Manatee, Manatee County, Florida. The Maritime Administration and Coast Guard request public comments on the FEIS and application. Publication of this notice begins a 45-day comment period and provides information on how to participate in the process.

DATES: A public hearing will be held in Palmetto, Florida on July 28, 2009. The public hearing will be held from 5 p.m. to 7 p.m. and will be preceded by an informational open house from 3 p.m. to 4:30 p.m. The public hearing may end later than the stated time, depending on the number of persons wishing to speak.

Material submitted in response to the request for comments on the FEIS and application must reach the Docket Management Facility by August 23, 2009.

Federal and State agencies must also submit comments, recommended conditions for licensing, or letters of no objection by September 11, 2009. Also by September 11, 2009, the Governor of Florida (the adjacent coastal state) may approve, disapprove, or notify the Maritime Administration of inconsistencies with State programs relating to environmental protection, land and water use, and coastal zone management for which the Maritime Administration may condition the license to make consistent.

The Maritime Administration must issue a record of decision (ROD) to approve, approve with conditions, or deny the DWP license application by October 26, 2009.

ADDRESSES: The public hearing in Palmetto will be held at the Manatee Convention Center, 1 Haben Blvd., Palmetto, Florida, 34221; *telephone:* (941) 722–3244.

The FEIS, the application, comments and associated documentation are available for viewing at the Federal Docket Management System Web site: *http://www.regulations.gov* under docket number USCG–2006–28532. The FEIS is also available at the following public libraries:

Central Library—Bradenton, FL 34205
Braden River Library—Bradenton, FL 34203
South Manatee Branch—Bradenton, FL 34207
Palmetto Branch Library—Palmetto, FL 34221
Rocky Bluff Library—Ellenton, FL 34222

Island Branch Library—Holmes Beach, FL 34217

Docket submissions for USCG–2006–28532 should be addressed to: Department of Transportation, Docket Management Facility, West Building, Ground Floor, Room W12–140, 1200 New Jersey Avenue, SE., Washington, DC 20590–0001.

The Federal Docket Management Facility accepts hand-delivered submissions, and makes docket contents available for public inspection and copying at this address between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The Facility telephone number is 202–366–9329, the fax number is 202–493–2251, and the Web site for electronic submissions or for electronic access to docket contents is *http://www.regulations.gov*.

FOR FURTHER INFORMATION CONTACT: Ray Martin, U.S. Coast Guard, *telephone:* 202–372–1449, *e-mail: Raymond.W.Martin@uscg.mil* or Chris Hanan, U.S. Maritime Administration, *telephone:* 202–366–1900, *e-mail: Christopher.Hanan@dot.gov*. If you have questions on viewing the docket, call Renee V. Wright, Program Manager, Docket Operations, telephone 202–493–0402.

SUPPLEMENTARY INFORMATION:

Request for Comments

We request public comments or other information on the FEIS and application. The public hearing is not the only opportunity you have to comment. In addition to or in place of attending a hearing, you can submit comments to the Docket Management Facility during the public comment period (*see* **DATES**). The Coast Guard and the Maritime Administration will consider all comments and material received during the comment period.

Submissions should include:

- Docket number USCG–2006–28532.
- Your name and address.

Submit comments or material using only one of the following methods:

- Electronic submission to FDMS, *http://www.regulations.gov*.
- Fax, mail, or hand delivery to the Docket Management Facility (*see* **ADDRESSES**). Faxed or hand delivered submissions must be unbound, no larger than 8½ by 11 inches, and suitable for copying and electronic scanning. If you mail your submission and want to know when it reaches the Facility, include a stamped, self-addressed postcard or envelope.

Regardless of the method used for submitting comments or material, all submissions will be posted, without change, to the FDMS Web site (*http://www.regulations.gov*), and will include any personal information you provide. Therefore, submitting this information makes it public. You may wish to read the Privacy and Use Notice that is available on the FDMS Web site, and the Department of Transportation Privacy Act Notice that appeared in the **Federal Register** on April 11, 2000 (65 FR 19477), see PRIVACY ACT.

Background

Information about deepwater ports, the statutes, and regulations governing their licensing, and the receipt of the current application for a liquefied natural gas (LNG) deepwater port was published in the **Federal Register** in Volume 72 FR 34741, on June 25, 2007. The Notice of Intent to Prepare an EIS for the proposed action was published in the **Federal Register** in Volume 72 FR 38116, on July 12, 2007 and the Notice of Availability of the Draft EIS was published in Volume 73 FR 21012, on April 17, 2008. The FEIS, application materials and associated comments are available on the docket. Information from the ''Summary of the Application'' from previous **Federal Register** notices is included below for your convenience.

Proposed Action and Alternatives

The proposed action requiring environmental review is the Federal licensing of the proposed deepwater port described in ''Summary of the Application'' below. The alternatives to licensing the proposed port are: (1) Licensing with conditions (including conditions designed to mitigate environmental impact), and (2) denying the application, which for purposes of environmental review is the ''no-action'' alternative. These alternatives are more fully discussed in the FEIS. The Coast Guard and the Maritime Administration are the lead Federal agencies for the preparation of the EIS. You can address any questions about the proposed action or the FEIS to the Coast Guard project manager identified in **FOR FURTHER INFORMATION CONTACT**.

Summary of the Application

Port Dolphin Energy LLC, proposes to own, construct, and operate a deepwater port, named Port Dolphin, in the Federal waters of the Outer Continental Shelf in the St. Petersburg (PB) blocks: PB545 and PB589, approximately 28 miles off the west coast of Florida to the southwest of Tampa Bay, in a water depth of approximately 100 feet. Port Dolphin would consist of a permanently moored unloading buoy system with two submersible buoys separated by a distance of approximately three miles. Each unloading buoy would be permanently secured to eight mooring lines, consisting of wire rope, chain, and buoyancy elements, each attached to anchor points on the seabed. Anchor points would consist most likely of driven piles.

The buoys would be designed to moor specialized type of LNG vessels called Shuttle and Regasification Vessels (SRVs) of 145,000 and 217,000 cubic meter capacities. SRVs are equipped to vaporize cryogenic LNG cargo to natural gas through an onboard closed loop vaporization system, and meter gas for send-out by means of the unloading buoy to conventional subsea pipelines. The SRVs would moor to the unloading buoys which connect through the hull of the vessels to specially designed turrets that would enable the vessels to weathervane or rotate in response to prevailing wind, wave, and current directions. When the vessels are not present, the buoys would be submerged on a special landing pad on the seabed, 60–70 feet below the sea surface.

Each unloading buoy would connect through a 16-inch flexible riser and a 36-inch flowline to a Y intersection and then a 36-inch pipeline approximately 42 miles in length that would connect onshore in Port Manatee, Manatee County, Florida. The pipeline would connect with the Gulfstream Natural Gas System, LLC and Tampa Electric Company (TECO).

The 36-inch gas transmission line will make landfall on Port Manatee property. From there, the transmission pipeline will proceed in a generally easterly direction to the first interconnection point with the Gulfstream system at 4 miles. The Gulfstream/TECO Interconnection Station will occupy an approximately 3.4-acre site. Up to approximately 70 percent of the natural gas is expected to be delivered to the Gulfstream pipeline and 30 percent to the TECO pipeline.

Only shuttle and regasification vessels (SRVs) will call on Port Dolphin. Offloading should require between 4–8 days and when empty the SRV would disconnect from the buoy and leave the port. Port Dolphin would have an average throughput capacity of 800 MMscfd with a peak capacity of 1200 MMscfd. The two separate buoys would allow natural gas to be delivered in a continuous flow, without interruption, by having a brief overlap between arriving and departing SRVs.

Port Dolphin Energy LLC is seeking Federal Energy Regulatory Commission (FERC) approval for the onshore pipelines concurrent with this deepwater port application. As required by FERC regulations, FERC will also maintain a docket for the FERC portion

of the project. The docket numbers are CP07–191–000 and CP07–192–000. The filing may also be viewed on the web at *http://www.ferc.gov* using the ''eLibrary'' link. Enter the docket number excluding the last three digits in the docket number field to access the document. For assistance, call (866) 208–3767 or TYY, (202) 502–8659.

In addition, pipelines and structures such as the moorings may require permits under Section 404 of the Clean Water Act and Section 10 of the Rivers and Harbors Act which are administered by the Army Corps of Engineers (USACE).

Port Dolphin will also require permits from the Environmental Protection Agency (EPA) pursuant to the provisions of the Clean Air Act, as amended, and the Clean Water Act, as amended.

Construction of the deepwater port would be expected to take approximately 11 months with startup of commercial operations following construction, should a license be issued. The deepwater port would be designed, constructed and operated in accordance with applicable codes and standards.

Privacy Act

The electronic form of all comments received into the Federal Docket Management System can be searched by the name of the individual submitting the comment (or signing the comment, if submitted on behalf of an association, business, labor union, etc.). The DOT Privacy Act Statement can be viewed in the **Federal Register** published on April 11, 2000 (Volume 65, Number 70, pages 19477–78) or you may visit *http://www.regulations.gov*.

(Authority 49 CFR 1.66)

Dated: July 2, 2009.

By Order of the Maritime Administrator.

Christine Gurland,

Acting Secretary, Maritime Administration.

[FR Doc. E9–16502 Filed 7–10–09; 8:45 am]

BILLING CODE P

DEPARTMENT OF TRANSPORTATION

Federal Railroad Administration

Petition for Waiver of Compliance

In accordance with Part 211 of Title 49 Code of Federal Regulations (CFR), notice is hereby given that the Federal Railroad Administration (FRA) received a request for a waiver of compliance with certain requirements of its safety standards. The individual petition is described below; including the party seeking relief, the regulatory provisions involved, the nature of the relief being requested, and the petitioner's arguments in favor of relief.

Kenwood U.S.A. Corporation

[(Waiver Petition Docket Number FRA–2009–0059]

Kenwood U.S.A. Corporation (Kenwood) seeks a waiver of compliance from certain provisions of 49 CFR part 232, Brake System Safety Standards for Freight and Other Non-Passenger Trains and Equipment. Specifically, § 232.409(d)—Inspection and Testing of end-of-train devices, which requires the telemetry equipment to be tested for accuracy and calibrated if necessary at least every 368 days. It also requires that the date and location of the last calibration or test, as well as the name of the person performing the calibration or test, be legibly displayed on a weather-resistant sticker or other marking device affixed to the outside of both the front and the rear unit.

This waiver will cover all Kenwood model NX–800–K UHF digital transceivers manufactured on or after August 24, 2007. This transceiver is competitive with a digitally synthesized radio produced by Wabtec, for which a similar waiver was granted (see Docket Number FRA–2004–18895); and Kenwood requests that its product be treated in a similar fashion.

Kenwood states that its NX–800–K device is inherently stable, reflecting the state of the art in digital synthesized transceivers. Test results submitted by Kenwood as part of its Federal Communications Commission (FCC) authorization process confirm the extreme frequency stability of this digital synthesized device. This compliance meets the (FCC) TIA–603 standard and current FCC Part 90 service rule specifications for railroad applications. Kenwood states that, as such, annual re-certification is unnecessary and administratively burdensome. Kenwood further states that the annual re-certification requirement was developed at the time when such radios were crystal controlled and stability was an issue, and that the rule has no application to digitally synthesized modern transceivers. Kenwood believes that the spirit of the rule is not violated by the requested waiver inasmuch as the radio design obviates the need for the annual certification and measurements.

Interested parties are invited to participate in these proceedings by submitting written views, data, or comments. FRA does not anticipate scheduling a public hearing in connection with these proceedings since the facts do not appear to warrant a hearing. If any interested party desires an opportunity for oral comment, they should notify FRA, in writing, before the end of the comment period and specify the basis for their request.

All communications concerning these proceedings should identify the appropriate docket number (*e.g.*, Waiver Petition Docket Number FRA–2009–0059) and may be submitted by any of the following methods:

- *Web site: http://www.regulations.gov*. Follow the online instructions for submitting comments.
- *Fax:* 202–493–2251.
- *Mail:* Docket Operations Facility, U.S. Department of Transportation, 1200 New Jersey Avenue, SE., W12–140, Washington, DC 20590.
- *Hand Delivery:* 1200 New Jersey Avenue, SE., Room W12–140, Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal Holidays.

Communications received within 30 days of the date of this notice will be considered by FRA before final action is taken. Comments received after that date will be considered as far as practicable. All written communications concerning these proceedings are available for examination during regular business hours (9 a.m.–5 p.m.) at the above facility. All documents in the public docket are also available for inspection and copying on the Internet at the docket facility's Web site at *http://www.regulations.gov*.

Anyone is able to search the electronic form of any written communications and comments received into any of our dockets by the name of the individual submitting the comment (or signing the comment, if submitted on behalf of an association, business, labor union, *etc.*). You may review DOT's complete Privacy Act Statement in the **Federal Register** published on April 11, 2000 (Volume 65, Number 70; Pages 19477–78).

Issued in Washington, DC, on July 7, 2009.

Grady C. Cothen, Jr.,

Deputy Associate Administrator for Safety Standards and Program Development.

[FR Doc. E9–16506 Filed 7–13–09; 8:45 am]

BILLING CODE 4910–06–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Proposed Collection; Comment Request for Revenue Procedure 2003–38

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice and request for comments.

SUMMARY: The Department of the Treasury, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity to comment on proposed and/or continuing information collections, as required by the Paperwork Reduction Act of 1995, Public Law 104–13 (44 U.S.C. 3506(c)(2)(A)). Currently, the IRS is soliciting comments concerning Revenue Procedure 2003–38, Commercial Revitalization Deduction.

DATES: Written comments should be received on or before September 11, 2009 to be assured of consideration.

ADDRESSES: Direct all written comments to R. Joseph Durbala, Internal Revenue Service, room 6129, 1111 Constitution Avenue, NW., Washington, DC 20224.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of the revenue procedure should be directed to Dawn Bidne at Internal Revenue Service, Room 6129, 1111 Constitution Avenue, NW., Washington, DC 20224, or at (202) 622–3933, or through the Internet at *Dawn.E.Bidne@irs.gov*.

SUPPLEMENTARY INFORMATION:

Title: Commercial Revitalization Deduction.

OMB Number: 1545–1818.

Revenue Procedure Number: Revenue Procedure 2003–38.

Abstract: Pursuant to section 1400I of the Internal Revenue Code, Revenue Procedure 2003–38 provides the time and manner for states to make allocations of commercial revitalization expenditures to a new or substantially rehabilitated building that is placed in service in a renewal community.

Current Actions: There are no changes being made to the revenue procedure at this time.

Type of Review: Extension of a currently approved collection.

Affected Public: State, local and tribal governments, and business or other for-profit organizations.

Estimated Number of Respondents: 80.

Estimated Average Time per Respondent: 2 hours, 30 minutes.

Estimated Total Annual Burden Hour: 200.

The following paragraph applies to all of the collections of information covered by this notice:

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number. Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Request for Comments: Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval. All comments will become a matter of public record. *Comments are invited on:* (a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

Approved: June 29, 2009.

Allan Hopkins,

IRS Reports Clearance Officer.

[FR Doc. E9–16525 Filed 7–10–09; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Proposed Collection; Comment Request for Notice 2006–26

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice and request for comments.

SUMMARY: The Department of the Treasury, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity to comment on proposed and/or continuing information collections, as required by the Paperwork Reduction Act of 1995, Public Law 104–13 (44 U.S.C. 3506(c)(2)(A)). Currently, the IRS is soliciting comments concerning Notice 2006–26, Credit for Nonbusiness Energy Property.

DATES: Written comments should be received on or before September 11, 2009 to be assured of consideration.

ADDRESSES: Direct all written comments to R. Joseph Durbala, Internal Revenue Service, Room 6129, 1111 Constitution Avenue, NW., Washington, DC 20224.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of notice should be directed to Allan Hopkins, at (202) 622–6665, or at Internal Revenue Service, Room 6129, 1111 Constitution Avenue, NW., Washington, DC 20224, or through the Internet, at *Allan.M.Hopkins@irs.gov*.

SUPPLEMENTARY INFORMATION:

Title: Credit for Nonbusiness Energy Property.

OMB Number: 1545–1989.

Notice Number: Notice 2006–26.

Abstract: This notice of interim guidance relates to the procedures by which a manufacturer can certify that building envelope components or energy property qualify for the section 25C credit. This notice is intended to provide (1) guidance concerning the methods by which manufacturers can provide such certifications to taxpayers, and (2) guidance concerning the methods by which taxpayers can claim such credits.

Current Actions: There are no changes being made to the notice at this time.

Type of Review: Extension of a currently approved collection.

Affected Public: Individuals or Households.

Estimated Number of Respondents: 140.

Estimated Average Time Per Respondent: 2.5 hrs.

Estimated Total Annual Burden Hours: 350.

The following paragraph applies to all of the collections of information covered by this notice:

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number. Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Request for Comments: Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval. All comments will become a matter of public record. Comments are invited on: (a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate

of the burden of the collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

Approved: June 29, 2009.

Allan Hopkins,

IRS Reports Clearance Officer.

[FR Doc. E9–16527 Filed 7–10–09; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Proposed Collection; Comment Request for Form 8907

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice and request for comments.

SUMMARY: The Department of the Treasury, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity to comment on proposed and/or continuing information collections, as required by the Paperwork Reduction Act of 1995, Public Law 104–13 (44 U.S.C. 3506(c)(2)(A)). Currently, the IRS is soliciting comments concerning Form 8907, Nonconventional Source Fuel Credit.

DATES: Written comments should be received on or before September 11, 2009 to be assured of consideration.

ADDRESSES: Direct all written comments to R. Joseph Durbala, Internal Revenue Service, room 6129, 1111 Constitution Avenue NW., Washington, DC 20224.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of the form and instructions should be directed to Dawn Bidne, (202) 622–3933, at Internal Revenue Service, Room 6129, 1111 Constitution Avenue, NW., Washington, DC 20224, or through the Internet at *Dawn.E.Bidne@irs.gov*.

SUPPLEMENTARY INFORMATION:

Title: Nonconventional Source Fuel Credit.

OMB Number: 1545–2008.

Form Number: Form 8907.

Abstract: Form 8907 will be used to claim a credit from the production and sale of fuel created from nonconventional sources. For tax years ending after 12/31/05 fuel from coke or coke gas can qualify for the credit, and the credit becomes part of the general business credit.

Current Actions: There is no change in the paperwork burden previously approved by OMB. This form is being submitted for renewal purposes only.

Type of Review: Extension of a currently approved collection.

Affected Public: Businesses and other for-profit organizations, individuals or households.

Estimated Number of Respondents: 22,000.

Estimated Time Per Respondent: 12 hours 41 minutes.

Estimated Total Annual Burden Hours: 278,960.

The following paragraph applies to all of the collections of information covered by this notice:

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number. Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Request For Comments: Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval. All comments will become a matter of public record. Comments are invited on: (a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

Approved: July 2, 2009.

R. Joseph Durbala,

IRS Reports Clearance Officer.

[FR Doc. E9–16529 Filed 7–10–09; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Proposed Collection; Comment Request for Form 13369

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice and request for comments.

SUMMARY: The Department of the Treasury, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity to comment on proposed and/or continuing information collections, as required by the Paperwork Reduction Act of 1995, Public Law 104–13 (44 U.S.C. 3506(c)(2)(A)). Currently, the IRS is soliciting comments concerning Form 13369, Agreement to Mediate.

DATES: Written comments should be received on or before September 11, 2009 to be assured of consideration.

ADDRESSES: Direct all written comments to R. Joseph Durbala, Internal Revenue Service, room 6129, 1111 Constitution Avenue, NW., Washington, DC 20224.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of the form and instructions should be directed to Bob Kennedy at Internal Revenue Service, room 6129, 1111 Constitution Avenue, NW., Washington, DC 20224, or at (202) 622–3403, or through the Internet at *(Robert.J.Kennedy@irs.gov).*

SUPPLEMENTARY INFORMATION:

Title: Agreement to Mediate.

OMB Number: 1545–1844.

Form Number: 13369.

Abstract: Fast Track Mediation is a dispute resolution process designed to expedite case resolution. In order to avail themselves of this process, taxpayers and Compliance must complete the Agreement to Mediate (Form 13369) once an examination or collection determination is made. Once signed by both parties, the Agreement to Mediate will be forwarded to Appeals to schedule a mediation session.

Current Actions: There are no changes being made to the form at this time.

Type of Review: Extension of a currently approved collection.

Affected Public: Individuals or households, business or other for-profit organizations, non-profit institutions, Federal, State, local or tribal governments.

Estimated Number of Respondents: 300.

Estimated Number of Respondents: 3 minutes.

Estimated Total Annual Burden Hours: 15.

The following paragraph applies to all of the collections of information covered by this notice:

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number. Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Request for Comments: Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval. All comments will become a matter of public record.

Comments are invited on: (a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

Approved: June 25, 2009.

Allan Hopkins,

IRS Reports Clearance Officer.

[FR Doc. E9–16530 Filed 7–10–09; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Proposed Collection; Comment Request for Form 8038–CP

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice and request for comments.

SUMMARY: The Department of the Treasury, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity to comment on proposed and/or continuing information collections, as required by the Paperwork Reduction Act of 1995, Public Law 104–13 (44 U.S.C. 3506(c)(2)(A)). Currently, the IRS is soliciting comments concerning Form 8038–CP, Return for Credit Payments to Issuers of Qualified Bonds.

DATES: Written comments should be received on or before September 11, 2009 to be assured of consideration.

ADDRESSES: Direct all written comments to R. Joseph Durbala, Internal Revenue Service, Room 6129, 1111 Constitution Avenue, NW., Washington, DC 20224.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of the form and instructions should be directed to Dawn Bidne, (202) 622–3933, at Internal Revenue Service, Room 6129, 1111 Constitution Avenue, NW., Washington, DC 20224, or through the Internet at *Dawn.E.Bidne@irs.gov*.

SUPPLEMENTARY INFORMATION:

Title: Return for Credit Payments to Issuers of Qualified Bonds.

OMB Number: 1545–2142.

Form Number: Form 8038–CP.

Abstract: Form 8038–CP, Return for Credit Payments to Issuers of Qualified Bonds, was developed to carry out the provisions of the American Recovery and Reinvestment Act of 2009. It provides State and local governments with the option of issuing a tax credit bond instead of a tax-exempt governmental obligation bond. The bill gives State and local governments the option to receive a direct payment from the Federal government equal to a subsidy that would have been received through the Federal tax credit for bonds.

Current Actions: There is no change in the paperwork burden previously approved by OMB. This form is being submitted for renewal purposes only.

Type of Review: Extension of a currently approved collection.

Affected Public: Businesses and other for-profit organizations, farms.

Estimated Number of Respondents: 500.

Estimated Time per Respondent: 8 hours 4 minutes.

Estimated Total Annual Burden Hours: 4,030.

The following paragraph applies to all of the collections of information covered by this notice:

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number. Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Request for Comments: Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval. All comments will become a matter of public record. Comments are invited on: (a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

Approved: July 7, 2009.

R. Joseph Durbala,

IRS Reports Clearance Officer.

[FR Doc. E9–16532 Filed 7–10–09; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Proposed Collection; Comment Request for Regulation Project

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice and request for comments.

SUMMARY: The Department of the Treasury, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity to comment on proposed and/or continuing information collections, as required by the Paperwork Reduction Act of 1995, Public Law 104–13 (44 U.S.C. 3506(c)(2)(A)). Currently, the IRS is soliciting comments concerning Form 8935, Airline Payments Report, and Form 8935–T, Transmittal of Airline Payments Reports.

DATES: Written comments should be received on or before September 11, 2009 to be assured of consideration.

ADDRESSES: Direct all written comments to R. Joseph Durbala, Internal Revenue Service, Room 6129, 1111 Constitution Avenue, NW., Washington, DC 20224.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of this regulation should be

directed to Dawn Bidne, (202) 622–3933, Internal Revenue Service, Room 6129, 1111 Constitution Avenue, NW., Washington, DC 20224, or through the Internet at *Dawn.E.Bidne@irs.gov*.

SUPPLEMENTARY INFORMATION:

Title: Permitted Elimination of Preretirement Optional Forms of Benefit.

OMB Number: 1545–2140.

Form Number: Form 8935 and Form 8935–T.

Abstract: Form 8935 will provide to the employee, current or former, the amount of the payment that was received from the airline that is eligible for rollover treatment into a Roth IRA. Form 8935–T (Transmittal form) will provide the Secretary the names, years, and amounts of such payments.

Current Actions: There is no change to this existing regulation.

Type of Review: Extension of a currently approved collection.

Affected Public: Business or other for-profit organizations and not-for-profit institutions.

Estimated Number of Respondents: 5.

Estimated Average Time per Respondent: 6 hours and 24 minutes.

Estimated Total Annual Burden Hours: 32.

The following paragraph applies to all of the collections of information covered by this notice:

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number. Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Request for Comments: Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval. All comments will become a matter of public record. *Comments are invited on:* (a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

Approved: July 7, 2009.

R. Joseph Durbala,

IRS Reports Clearance Officer.

[FR Doc. E9–16534 Filed 7–10–09; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Proposed Collection; Comment Request for Revenue Procedure 2003–39

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice and request for comments.

SUMMARY: The Department of the Treasury, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity to comment on proposed and/or continuing information collections, as required by the Paperwork Reduction Act of 1995, Public Law 104–13 (44 U.S.C. 3506(c)(2)(A)). Currently, the IRS is soliciting comments concerning Revenue Procedure 2003–39, section 1031 LKE (Like-Kind Exchanges) Auto Leasing Programs.

DATES: Written comments should be received on or before September 11, 2009 to be assured of consideration.

ADDRESSES: Direct all written comments to R. Joseph Durbala, Internal Revenue Service, Room 6129, 1111 Constitution Avenue, NW., Washington, DC 20224.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of the revenue procedure should be directed to Dawn Bidne at Internal Revenue Service, Room 6129, 1111 Constitution Avenue, NW., Washington, DC 20224, or at (202) 622–3933, or through the Internet at *Dawn.E.Bidne@irs.gov.*

SUPPLEMENTARY INFORMATION:

Title: Section 1031 LKE (Like-Kind Exchanges) Auto Leasing Programs.

OMB Number: 1545–1834.

Revenue Procedure Number: Revenue Procedure 2003–39.

Abstract: Revenue Procedure 2003–39 provides safe harbors for certain aspects of the qualification under section 1031 of certain exchanges of property pursuant to LKE Programs for Federal income tax purposes.

Current Actions: There are no changes being made to the revenue procedure at this time.

Type of Review: Extension of a currently approved collection.

Affected Public: Business or other for-profit organizations.

Estimated Number of Respondents: 8,600.

Estimated Average Time Per Respondent: 1 hour.

Estimated Total Annual Burden Hours: 8,600.

The following paragraph applies to all of the collections of information covered by this notice:

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number. Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Request for Comments: Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval. All comments will become a matter of public record. Comments are invited on: (a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

Approved: June 29, 2009.

Allan Hopkins,

IRS Reports Clearance Officer.

[FR Doc. E9–16535 Filed 7–10–09; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Proposed Collection; Comment Request for Notice 2009–26

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice and request for comments.

SUMMARY: The Department of the Treasury, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity to comment on proposed and/or continuing information collections, as required by the Paperwork Reduction Act of 1995, Public Law 104–13 (44 U.S.C. 3506(c)(2)(A)). Currently, the IRS is soliciting comments concerning Notice 2009–26, Build America Bonds and Direct Payment Subsidy Implementation.

DATES: Written comments should be received on or before September 11, 2009 to be assured of consideration.

ADDRESSES: Direct all written comments to R. Joseph Durbala, Internal Revenue Service, room 6129, 1111 Constitution Avenue, NW., Washington, DC 20224.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of this regulation should be directed to Dawn Bidne, (202) 622–3933, Internal Revenue Service, room 6129, 1111 Constitution Avenue, NW., Washington, DC 20224, or through the Internet at *Dawn.E.Bidne@irs.gov*.

SUPPLEMENTARY INFORMATION:

Title: Build America Bonds and Direct Payment Subsidy Implementation.

OMB Number: 1545–2143.

Notice Number: Notice 2009–26.

Abstract: This Notice provides guidance on the new tax incentives for Build America Bonds under section 54AA of the Internal Revenue Code (''Code'') and the implementation plans for the refundable credit payment procedures for these bonds. This Notice includes guidance on the modified Build America Bond program for Recovery Zone Economic Development Bonds under section 1400U–2 of the Code. This Notice provides guidance on the initial refundable credit payment procedures, required elections, and information reporting. This Notice solicits public comments on the refundable credit payment procedures for these bonds. This Notice is intended to facilitate prompt implementation of the Build America Bond program and to enable state and local governments to begin issuing these bonds for authorized purposes to promote economic recovery and job creation.

Current Actions: There is no change to this existing regulation.

Type of Review: Extension of a currently approved collection.

Affected Public: Business or other for-profit organizations and not-for-profit institutions.

Estimated Number of Respondents: 1,000.

Estimated Average Time per Respondent: 15 hours.

Estimated Total Annual Burden Hours: 15,000.

The following paragraph applies to all of the collections of information covered by this notice:

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number. Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Request for Comments: Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval. All comments will become a matter of public record. Comments are invited on: (a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

Approved: July 7, 2009.

R. Joseph Durbala,

IRS Reports Clearance Officer.

[FR Doc. E9–16523 Filed 7–10–09; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Proposed Collection; Comment Request for Notice 2000–28

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice and request for comments.

SUMMARY: The Department of the Treasury, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity to comment on proposed and/or continuing information collections, as required by the Paperwork Reduction Act of 1995, Public Law 104–13 (44 U.S.C. 3506(c)(2)(A)). Currently, the IRS is soliciting comments concerning Notice 2000–28, Coal Exports.

DATES: Written comments should be received on or before September 11, 2009 to be assured of consideration.

ADDRESSES: Direct all written comments to R. Joseph Durbala, Internal Revenue Service, Room 6129, 1111 Constitution Avenue, NW., Washington, DC 20224.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of the regulations should be directed to Bob Kennedy at Internal Revenue Service, Room 6129, 1111 Constitution Avenue, NW., Washington, DC 20224, or at (202) 622–3403, or through the Internet at (*Robert.J.Kennedy@irs.gov*).

SUPPLEMENTARY INFORMATION:

Title: Coal Exports.

Notice Number: 1545–1690.

Abstract: Notice 2000–28 provides guidance relating to the coal excise tax imposed by section 4121 of the Internal Revenue Code. The notice provides rules under the Code for making a nontaxable sale of coal for export or for obtaining a credit or refund when tax has been paid with respect to a nontaxable sale of coal for export.

Current Actions: There are no changes being made to the notice at this time.

Type of Review: Extension of currently approved collection.

Affected Public: Business or other-for-profit organizations.

Estimated Number of Respondents: 400.

Estimated Time Per Respondent: 1 hour.

Estimated Total Annual Burden Hours: 400.

The following paragraph applies to all of the collections of information covered by this notice:

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number. Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Request For Comments: Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval. All comments will become a matter of

public record. Comments are invited on: (a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

Approved: June 25, 2009.

Allan Hopkins,

IRS Reports Clearance Officer.

[FR Doc. E9–16546 Filed 7–10–09; 8:45 am]

BILLING CODE 4830–01–P

Federal Register

Monday,
July 13, 2009

Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 410, 411, 414, et al.
Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 410, 411, 414, 415, and 485

[CMS–1413–P]

RIN 0938–AP40

Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would address proposed changes to Medicare Part B payment policy. We are proposing these changes to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services. This proposed rule discusses: Refinements to resource-based work, practice expense and malpractice relative value units (RVUs); geographic practice cost indices (GPCIs); telehealth services; several coding issues; physician fee schedule update for CY 2010; payment for covered part B outpatient drugs and biologicals; the competitive acquisition program (CAP); payment for renal dialysis services; the chiropractic services demonstration; comprehensive outpatient rehabilitation facilities; physician self-referral; the ambulance fee schedule; the clinical laboratory fee schedule; durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS); and certain provisions of the Medicare Improvements for Patients and Providers Act of 2008. (*See* the Table of contents for a listing of the specific issues.)

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on Monday, August 31, 2009.

ADDRESSES: In commenting, please refer to file code CMS–1413–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically*. You may submit electronic comments on this regulation to *http://www.regulations.gov*. Follow the instructions under the ''More Search Options'' tab.

2. *By regular mail*. You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1413–P, P.O. Box 8013, Baltimore, MD 21244–8013.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail*. You may send written comments to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1413–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier*. If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–9994 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

FOR FURTHER INFORMATION CONTACT:

Rick Ensor, (410) 786–5617, for issues related to practice expense methodology.

Craig Dobyski, (410) 786–4584, for issues related to geographic practice cost indices.

Esther Markowitz, (410) 786–4595, for issues related to telehealth services.

Ken Marsalek, (410) 786–4502, for issues related to the physician practice information survey and the multiple procedure payment reduction.

Cathleen Scally, (410) 786–5714, for issues related to the initial preventive physical examination or consultation services.

Regina Walker-Wren, (410) 786–9160, for issues related to the phasing out of the outpatient mental health treatment limitation.

Diane Stern, (410) 786–1133, for issues related to the physician quality reporting initiative and incentives for e-prescribing.

Lisa Grabert, (410) 786–6827, for issues related to the Physician Resource Use Feedback Program.

Colleen Bruce, (410) 786–5529, for issues related to value-based purchasing.

Sandra Bastinelli, (410) 786–3630, for issues related to the implementation of accreditation standards.

Jim Menas, (410) 786–4507, for issues related to teaching anesthesia services.

Sarah McClain, (410) 786–2994, for issues related to the coverage of cardiac rehabilitation services.

Dorothy Shannon, (410) 786–3396, for issues related to payment for cardiac rehabilitation services.

Roya Lofti, (410) 786–4072, for issues related to the coverage of pulmonary rehabilitation.

Jamie Hermansen, (410) 786–2064, for issues related to kidney disease patient education programs.

Terri Harris, (410) 786–6830 for issues related to payment for kidney disease patient education.

Henry Richter, (410) 786–4562, or Lisa Hubbard, (410) 786–5472, for issues related to renal dialysis provisions and payments for end-stage renal disease facilities.

Cheryl Gilbreath, (410) 786–5919, for issues related to payment for covered outpatient drugs and biologicals.

Edmund Kasaitis, (410) 786–0477, or Bonny Dahm, (410) 786–4006, for issues related to the Competitive Acquisition Program (CAP) for Part B drugs.

Pauline Lapin, (410) 786–6883, for issues related to the chiropractic services demonstration budget neutrality issue.

Monique Howard, (410) 786–3869, for issues related to CORF conditions of coverage.

Roechel Kujawa, (410) 786–9111, for issues related to ambulance services.

Anne Tayloe Hauswald, (410) 786–4546, for clinical laboratory issues.

Troy Barsky, (410) 786–8873, or Roy Albert, (410) 786–1872, for issues related to physician self-referral.

Michelle Peterman, (410) 786–2591, or Iffat Fatima, (410) 786–6709 for issues related to the grandfathering

provisions of the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) Competitive Acquisition Program.

Ralph Goldberg, (410) 786–4870, or Heidi Edmunds, (410) 786–1781, for issues related to the damages process caused by the termination of contracts awarded in 2008 under the DMEPOS Competitive Bidding program.

Diane Milstead, (410) 786–3355, or Gaysha Brooks, (410) 786–9649, for all other issues.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.regulations.gov*. Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

Table of Contents

To assist readers in referencing sections contained in this preamble, we are providing a table of contents. Some of the issues discussed in this preamble affect the payment policies, but do not require changes to the regulations in the *Code of Federal Regulations* (CFR). Information on the regulation's impact appears throughout the preamble, and therefore, is not exclusively in section V. of this proposed rule.

Addendum F—Proposed CY 2010 ESRD Wage Index for Urban Areas Based on CBSA Labor Market Areas
Addendum G—Propsoed CY 2010 ESRD Wage Index Based on CBSA Labor Market Areas for Rural Areas

Acronyms

In addition, because of the many organizations and terms to which we refer by acronym in this final rule with comment period, we are listing these acronyms and their corresponding terms in alphabetical order below:

AACVPR American Association of Cardiovascular and Pulmonary Rehabilitation
ACC American College of Cardiology
ACGME Accreditation Council on Graduate Medical Education
ACR American College of Radiology
AFROC Association of Freestanding Radiation Oncology Centers
AHA American Heart Association
AHRQ [HHS'] Agency for Healthcare Research and Quality
AIDS Acquired immune deficiency syndrome
AMA American Medical Association
AMP Average manufacturer price
AOA American Osteopathic Association
APA American Psychological Association
APTA American Physical Therapy Association
ASC Ambulatory surgical center
ASP Average sales price
ASRT American Society of Radiologic Technologists
ASTRO American Society for Therapeutic Radiology and Oncology
ATA American Telemedicine Association
AWP Average wholesale price
BBA Balanced Budget Act of 1997 (Pub. L. 105–33)
BBRA [Medicare, Medicaid and State Child Health Insurance Program] Balanced Budget Refinement Act of 1999 (Pub. L. 106–113)
BIPA Medicare, Medicaid, and SCHIP Benefits Improvement Protection Act of 2000 (Pub. L. 106–554)
BLS Bureau of Labor Statistics
BN Budget neutrality
CABG Coronary artery bypass graft
CAD Coronary artery disease
CAH Critical access hospital
CAHEA Committee on Allied Health Education and Accreditation
CAP Competitive acquisition program
CBSA Core-Based Statistical Area
CCHIT Certification Commission for Healthcare Information Technology
CEAMA Council on Education of the American Medical Association
CF Conversion factor
CfC Conditions for Coverage
CFR Code of Federal Regulations
CKD Chronic kidney disease
CLFS Clinical laboratory fee schedule
CMA California Medical Association
CMHC Community mental health center
CMP Civil money penalty
CMS Centers for Medicare & Medicaid Services
CNS Clinical nurse specialist
CoP Condition of participation
COPD Chronic obstructive pulmonary disease
CORF Comprehensive Outpatient Rehabilitation Facility
COS Cost of service
CPEP Clinical Practice Expert Panel
CPI Consumer Price Index
CPI–U Consumer price index for urban customers
CPT [Physicians'] Current Procedural Terminology (4th Edition, 2002, copyrighted by the American Medical Association)
CR Cardiac rehabilitation
CRNA Certified registered nurse anesthetist
CRP Canalith repositioning
CRT Certified respiratory therapist
CSW Clinical social worker
CY Calendar year
DHS Designated health services
DME Durable medical equipment
DMEPOS Durable medical equipment, prosthetics, orthotics, and supplies
DOQ Doctor's Office Quality
DRA Deficit Reduction Act of 2005 (Pub. L. 109–171)
DSMT Diabetes self-management training
E/M Evaluation and management
EDI Electronic data interchange
EEG Electroencephalogram
EHR Electronic health record
EKG Electrocardiogram
EMG Electromyogram
EMTALA Emergency Medical Treatment and Active Labor Act
EOG Electro-oculogram
EPO Erythropoietin
ESRD End-stage renal disease
FAX Facsimile
FDA Food and Drug Administration (HHS)
FEV Forced expiratory volume
FFS Fee-for-service
FR **Federal Register**
FVC Forced expiratory vital capacity (liters)
GAF Geographic adjustment factor
GAO General Accountability Office
GEM Generating Medicare [Physician Quality Performance Measurement Results]
GFR Glomerular filtration rate
GPO Group purchasing organization
GPCI Geographic practice cost index
HAC Hospital-acquired conditions
HBAI Health and behavior assessment and intervention
HCPAC Health Care Professional Advisory Committee
HCPCS Healthcare Common Procedure Coding System
HCRIS Healthcare Cost Report Information System
HDRT High dose radiation therapy
HH PPS Home Health Prospective Payment System
HHA Home health agency
HHRG Home health resource group
HHS [Department of] Health and Human Services
HIPAA Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191)
HIT Health information technology
HITECH Health Information Technology for Economic and Clinical Health Act (Title IV of Division B of the Recovery Act, together with Title XIII of Division A of the Recovery Act)
HITSP Healthcare Information Technology Standards Panel
HIV Human immunodeficiency virus
HOPD Hospital outpatient department
HPSA Health Professional Shortage Area
HRSA Health Resources Services Administration (HHS)
ICD International Classification of Diseases
IACS Individuals Access to CMS Systems
ICF Intermediate care facilities
ICR Intensive cardiac rehabilitation
ICR Information collection requirement
IDTF Independent diagnostic testing facility
IFC Interim final rule with comment period
IMRT Intensity-Modulated Radiation Therapy
IPPE Initial preventive physical examination
IPPS Inpatient prospective payment system
IRS Internal Revenue Service
ISO Insurance services office
IVD Ischemic Vascular Disease
IVIG Intravenous immune globulin
IWPUT Intra-service work per unit of time
JRCERT Joint Review Committee on Education in Radiologic Technology
JUA Joint underwriting association
KDE Kidney disease education
MA Medicare Advantage
MA–PD Medicare Advantage-Prescription Drug Plans
MCMP Medicare Care Management Performance
MedCAC Medicare Evidence Development and Coverage Advisory Committee (formerly the Medicare Coverage Advisory Committee (MCAC))
MedPAC Medicare Payment Advisory Commission
MEI Medicare Economic Index
MIEA–TRHCA Medicare Improvements and Extension Act of 2006 (that is, Division B of the Tax Relief and Health Care Act of 2006 (TRHCA) (Pub. L. 109–432)
MIPPA Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. 110–275)
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–173)
MMSEA Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. 110–173)
MNT Medical nutrition therapy
MP Malpractice
MPPR Multiple procedure payment reduction
MQSA Mammography Quality Standards Act of 1992 (Pub. L. 102–539)
MRA Magnetic resonance angiography
MRI Magnetic resonance imaging
MS-DRG Medicare Severity-Diagnosis related group
MSA Metropolitan statistical area
NCD National Coverage Determination
NCH National Claims History
NCPDP National Council for Prescription Drug Programs
NCQDIS National Coalition of Quality Diagnostic Imaging Services
NDC National drug code
NF Nursing facility
NISTA National Institute of Standards and Technology Act
NP Nurse practitioner
NPDB National Practitioner Data Bank
NPI National Provider Identifier

NPP Nonphysician practitioner
NPPES National Plan and Provider Enumeration System
NQF National Quality Forum
NRC Nuclear Regulatory Commission
NTTAA National Technology Transfer and Advancement Act of 1995 (Pub. L. 104–113)
NUBC National Uniform Billing Committee
OACT [CMS'] Office of the Actuary
OBRA Omnibus Budget Reconciliation Act
ODF Open door forum
OIG Office of Inspector General
OMB Office of Management and Budget
ONC [HHS'] Office of the National Coordinator
OPPS Outpatient prospective payment system
OSA Obstructive Sleep Apnea
OSCAR Online Survey and Certification and Reporting
P4P Pay for performance
PA Physician assistant
PBM Pharmacy benefit manager
PC Professional component
PCF Patient compensation fund
PCI Percutaneous coronary intervention
PDE Prescription drug event
PDP Prescription drug plan
PE Practice expense
PE/HR Practice expense per hour
PEAC Practice Expense Advisory Committee
PECOS Provider Enrollment, Chain, and Ownership System
PERC Practice Expense Review Committee
PFS Physician Fee Schedule
PGP [Medicare] Physician Group Practice
PHP Partial hospitalization program
PIM [Medicare] Program Integrity Manual
PLI Professional liability insurance
POA Present on admission
POC Plan of care
PPI Producer price index
PPIS Physician Practice Information Survey
PPS Prospective payment system
PPTA Plasma Protein Therapeutics Association
PQRI Physician Quality Reporting Initiative
PRA Paperwork Reduction Act
PSA Physician scarcity areas
PSG Polysomnography
PT Physical therapy
PTCA Percutaneous transluminal coronary angioplasty
RA Radiology assistant
Recovery Act American Recovery and Reinvestment Act (Pub. L. 111–5)
ResDAC Research Data Assistance Center
RFA Regulatory Flexibility Act
RIA Regulatory impact analysis
RN Registered nurse
RNAC Reasonable net acquisition cost
RPA Radiology practitioner assistant
RRT Registered respiratory therapist
RUC [AMA's Specialty Society] Relative (Value) Update Committee
RVU Relative value unit
SBA Small Business Administration
SGR Sustainable growth rate
SLP Speech-language pathology
SMS [AMA's] Socioeconomic Monitoring System
SNF Skilled nursing facility
SOR System of record
SRS Stereotactic radiosurgery
TC Technical Component
TIN Tax identification number
TRHCA Tax Relief and Health Care Act of 2006 (Pub. L. 109–432)
TTO Transtracheal oxygen
UPMC University of Pittsburgh Medical Center
USDE United States Department of Education
VBP Value-based purchasing
WAMP Widely available market price

I. Background

Since January 1, 1992, Medicare has paid for physicians' services under section 1848 of the Social Security Act (the Act), ''Payment for Physicians' Services.'' The Act requires that payments under the physician fee schedule (PFS) be based on national uniform relative value units (RVUs) based on the relative resources used in furnishing a service. Section 1848(c) of the Act requires that national RVUs be established for physician work, practice expense (PE), and malpractice expense. Before the establishment of the resource-based relative value system, Medicare payment for physicians' services was based on reasonable charges.

A. Development of the Relative Value System

1. Work RVUs

The concepts and methodology underlying the PFS were enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1989 (Pub. L. 101–239), and OBRA 1990, (Pub. L. 101–508). The final rule, published on November 25, 1991 (56 FR 59502), set forth the fee schedule for payment for physicians' services beginning January 1, 1992. Initially, only the physician work RVUs were resource-based, and the PE and malpractice RVUs were based on average allowable charges.

The physician work RVUs established for the implementation of the fee schedule in January 1992 were developed with extensive input from the physician community. A research team at the Harvard School of Public Health developed the original physician work RVUs for most codes in a cooperative agreement with the Department of Health and Human Services (DHHS). In constructing the code-specific vignettes for the original physician work RVUs, Harvard worked with panels of experts, both inside and outside the Federal government, and obtained input from numerous physician specialty groups.

Section 1848(b)(2)(B) of the Act specifies that the RVUs for anesthesia services are based on RVUs from a uniform relative value guide, with appropriate adjustment of the conversion factor (CF), in a manner to assure that fee schedule amounts for anesthesia services are consistent with those for other services of comparable value. We established a separate CF for anesthesia services, and we continue to utilize time units as a factor in determining payment for these services. As a result, there is a separate payment methodology for anesthesia services.

We establish physician work RVUs for new and revised codes based on our review of recommendations received from the American Medical Association's (AMA) Specialty Society Relative Value Update Committee (RUC).

2. Practice Expense Relative Value Units (PE RVUs)

Section 121 of the Social Security Act Amendments of 1994 (Pub. L. 103–432), enacted on October 31, 1994, amended section 1848(c)(2)(C)(ii) of the Act and required us to develop resource-based PE RVUs for each physician's service beginning in 1998. We were to consider general categories of expenses (such as office rent and wages of personnel, but excluding malpractice expenses) comprising PEs.

Section 4505(a) of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33), amended section 1848(c)(2)(C)(ii) of the Act to delay implementation of the resource-based PE RVU system until January 1, 1999. In addition, section 4505(b) of the BBA provided for a 4-year transition period from charge-based PE RVUs to resource-based RVUs.

We established the resource-based PE RVUs for each physicians' service in a final rule, published November 2, 1998 (63 FR 58814), effective for services furnished in 1999. Based on the requirement to transition to a resource-based system for PE over a 4-year period, resource-based PE RVUs did not become fully effective until 2002.

This resource-based system was based on two significant sources of actual PE data: The Clinical Practice Expert Panel (CPEP) data; and the AMA's Socioeconomic Monitoring System (SMS) data. The CPEP data were collected from panels of physicians, practice administrators, and nonphysicians (for example, registered nurses (RNs)) nominated by physician specialty societies and other groups. The CPEP panels identified the direct inputs required for each physician's service in both the office setting and out-of-office setting. We have since refined and revised these inputs based on recommendations from the RUC. The AMA's SMS data provided aggregate

specialty-specific information on hours worked and PEs.

Separate PE RVUs are established for procedures that can be performed in both a nonfacility setting, such as a physician's office, and a facility setting, such as a hospital outpatient department. The difference between the facility and nonfacility RVUs reflects the fact that a facility typically receives separate payment from Medicare for its costs of providing the service, apart from payment under the PFS. The nonfacility RVUs reflect all of the direct and indirect PEs of providing a particular service.

Section 212 of the Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113) directed the Secretary of Health and Human Services (the Secretary) to establish a process under which we accept and use, to the maximum extent practicable and consistent with sound data practices, data collected or developed by entities and organizations to supplement the data we normally collect in determining the PE component. On May 3, 2000, we published the interim final rule (65 FR 25664) that set forth the criteria for the submission of these supplemental PE survey data. The criteria were modified in response to comments received, and published in the **Federal Register** (65 FR 65376) as part of a November 1, 2000 final rule. The PFS final rules published in 2001 and 2003, respectively, (66 FR 55246 and 68 FR 63196) extended the period during which we would accept these supplemental data through March 1, 2005.

In the Calendar Year (CY) 2007 PFS final rule with comment period (71 FR 69624), we revised the methodology for calculating PE RVUs beginning in CY 2007 and provided for a 4-year transition for the new PE RVUs under this new methodology.

3. Resource-Based Malpractice (MP) RVUs

Section 4505(f) of the BBA amended section 1848(c) of the Act requiring us to implement resource-based malpractice (MP) RVUs for services furnished on or after 2000. The resource-based MP RVUs were implemented in the PFS final rule published November 2, 1999 (64 FR 59380). The MP RVUs were based on malpractice insurance premium data collected from commercial and physician-owned insurers from all the States, the District of Columbia, and Puerto Rico.

4. Refinements to the RVUs

Section 1848(c)(2)(B)(i) of the Act requires that we review all RVUs no less often than every 5 years. The first 5-Year Review of the physician work RVUs was published on November 22, 1996 (61 FR 59489) and was effective in 1997. The second 5-Year Review was published in the CY 2002 PFS final rule with comment period (66 FR 55246) and was effective in 2002. The third 5-Year Review of physician work RVUs was published in the CY 2007 PFS final rule with comment period (71 FR 69624) and was effective on January 1, 2007. (**Note:** Additional codes relating to the third 5-Year Review of physician work RVUs were addressed in the CY 2008 PFS final rule with comment period (72 FR 66360).)

In 1999, the AMA's RUC established the Practice Expense Advisory Committee (PEAC) for the purpose of refining the direct PE inputs. Through March 2004, the PEAC provided recommendations to CMS for over 7,600 codes (all but a few hundred of the codes currently listed in the AMA's Current Procedural Terminology (CPT) codes). As part of the CY 2007 PFS final rule with comment period (71 FR 69624), we implemented a new methodology for determining resource-based PE RVUs and are transitioning this over a 4-year period. (**Note:** In section II.A.2. of this proposed rule, we are proposing to use new survey data under the PE methodology.)

In the CY 2005 PFS final rule with comment period (69 FR 66236), we implemented the first 5-Year Review of the MP RVUs (69 FR 66263). (**Note**: In section II.C. of this proposed rule, we are proposing to update the malpractice RVUs with the use of new data.)

5. Adjustments to RVUs are Budget Neutral

Section 1848(c)(2)(B)(ii)(II) of the Act provides that adjustments in RVUs for a year may not cause total PFS payments to differ by more than $20 million from what they would have been if the adjustments were not made. In accordance with section 1848(c)(2)(B)(ii)(II) of the Act, if adjustments to RVUs cause expenditures to change by more than $20 million, we make adjustments to ensure that expenditures do not increase or decrease by more than $20 million.

As explained in the CY 2009 PFS final rule with comment period (73 FR 69730), as required by section 133(b) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110–275), the separate budget neutrality (BN) adjustor resulting from the third 5-Year Review of physician work RVUs is being applied to the CF beginning with CY 2009 rather than the work RVUs.

B. Components of the Fee Schedule Payment Amounts

To calculate the payment for every physicians' service, the components of the fee schedule (physician work, PE, and MP RVUs) are adjusted by a geographic practice cost index (GPCI). The GPCIs reflect the relative costs of physician work, PE, and malpractice expense in an area compared to the national average costs for each component.

RVUs are converted to dollar amounts through the application of a CF, which is calculated by CMS' Office of the Actuary (OACT).

The formula for calculating the Medicare fee schedule payment amount for a given service and fee schedule area can be expressed as:

$$\text{Payment} = [(\text{RVU work} \times \text{GPCI work}) + (\text{RVU PE} \times \text{GPCI PE}) + (\text{RVU malpractice} \times \text{GPCI malpractice})] \times \text{CF}$$

C. Most Recent Changes to the Fee Schedule

The CY 2009 PFS final rule with comment period (73 FR 69726) implemented changes to the PFS and other Medicare Part B payment policies finalized the CY 2008 interim RVUs and implemented interim RVUs for new and revised codes for CY 2009 to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services.

The CY 2009 PFS final rule with comment period also addressed other policies, as well as certain provisions of the MIPPA.

As required by the statute, and based on section 131 of the MIPPA, the CY 2009 PFS final rule with comment period also announced that the PFS update is 1.1 percent for CY 2009, the initial estimate for the sustainable growth rate for CY 2009 is 7.4 percent, and the conversion factor (CF) for CY 2009 is $36.0666.

II. Provisions of the Proposed Regulation

A. Resource-Based Practice Expense (PE) Relative Value Units (RVUs)

Practice expense (PE) is the portion of the resources used in furnishing the service that reflects the general categories of physician and practitioner expenses, such as office rent and personnel wages but excluding malpractice expenses, as specified in section 1848(c)(1)(B) of the Act.

Section 121 of the Social Security Amendments of 1994 (Pub. L. 103–432), enacted on October 31, 1994, required CMS to develop a methodology for a resource-based system for determining

PE RVUs for each physician's service. Until that time, PE RVUs were based on historical allowed charges. This legislation stated that the revised PE methodology must consider the staff, equipment, and supplies used in the provision of various medical and surgical services in various settings beginning in 1998. The Secretary has interpreted this to mean that Medicare payments for each service would be based on the relative PE resources typically involved with furnishing the service.

The initial implementation of resource-based PE RVUs was delayed from January 1, 1998, until January 1, 1999, by section 4505(a) of the BBA. In addition, section 4505(b) of the BBA required that the new payment methodology be phased in over 4 years, effective for services furnished in CY 1999, and fully effective in CY 2002. The first step toward implementation of the statute was to adjust the PE values for certain services for CY 1998. Section 4505(d) of the BBA required that, in developing the resource-based PE RVUs, the Secretary must—

- Use, to the maximum extent possible, generally-accepted cost accounting principles that recognize all staff, equipment, supplies, and expenses, not solely those that can be linked to specific procedures and actual data on equipment utilization.
- Develop a refinement method to be used during the transition.
- Consider, in the course of notice and comment rulemaking, impact projections that compare new proposed payment amounts to data on actual physician PE.

In CY 1999, we began the 4-year transition to resource-based PE RVUs utilizing a ''top-down'' methodology whereby we allocated aggregate specialty-specific practice costs to individual procedures. The specialty-specific PEs were derived from the American Medical Association's (AMA's) Socioeconomic Monitoring Survey (SMS). In addition, under section 212 of the BBRA, we established a process extending through March 2005 to supplement the SMS data with data submitted by a specialty. The aggregate PEs for a given specialty were then allocated to the services furnished by that specialty on the basis of the direct input data (that is, the staff time, equipment, and supplies) and work RVUs assigned to each CPT code.

For CY 2007, we implemented a new methodology for calculating PE RVUs. Under this new methodology, we use the same data sources for calculating PE, but instead of using the ''top-down'' approach to calculate the direct PE RVUs, under which the aggregate direct and indirect costs for each specialty are allocated to each individual service, we now utilize a ''bottom-up'' approach to calculate the direct costs. Under the ''bottom up'' approach, we determine the direct PE by adding the costs of the resources (that is, the clinical staff, equipment, and supplies) typically required to provide each service. The costs of the resources are calculated using the refined direct PE inputs assigned to each CPT code in our PE database, which are based on our review of recommendations received from the AMA's Relative Value Update Committee (RUC). For a more detailed explanation of the PE methodology, *see* the Five-Year Review of Work Relative Value Units Under the PFS and Proposed Changes to the Practice Expense Methodology proposed notice (71 FR 37242) and the CY 2007 PFS final rule with comment period (71 FR 69629).

Note: In section II.A.1 of this proposed rule, we discuss the current methodology used for calculating PE. In section II.A.2. of this proposed rule, which contains PE proposals for CY 2010, we are proposing to use data from the AMA Physician Practice Information Survey (PPIS) in place of the AMA's SMS survey data and supplemental survey data that is currently used in the PE methodology.

1. Current Methodology

a. Data Sources for Calculating Practice Expense

The AMA's SMS survey data and supplemental survey data from the specialties of cardiothoracic surgery, vascular surgery, physical and occupational therapy, independent laboratories, allergy/immunology, cardiology, dermatology, gastroenterology, radiology, independent diagnostic testing facilities (IDTFs), radiation oncology, and urology are used to develop the PE per hour (PE/HR) for each specialty. For those specialties for which we do not have PE/HR, the appropriate PE/HR is obtained from a crosswalk to a similar specialty.

The AMA developed the SMS survey in 1981 and discontinued it in 1999. Beginning in 2002, we incorporated the 1999 SMS survey data into our calculation of the PE RVUs, using a 5-year average of SMS survey data. (*See* the CY 2002 PFS final rule with comment period (66 FR 55246).) The SMS PE survey data are adjusted to a common year, 2005. The SMS data provide the following six categories of PE costs:

- Clinical payroll expenses, which are payroll expenses (including fringe benefits) for nonphysician clinical personnel.
- Administrative payroll expenses, which are payroll expenses (including fringe benefits) for nonphysician personnel involved in administrative, secretarial, or clerical activities.
- Office expenses, which include expenses for rent, mortgage interest, depreciation on medical buildings, utilities, and telephones.
- Medical material and supply expenses, which include expenses for drugs, x-ray films, and disposable medical products.
- Medical equipment expenses, which include depreciation, leases, and rent of medical equipment used in the diagnosis or treatment of patients.
- All other expenses, which include expenses for legal services, accounting, office management, professional association memberships, and any professional expenses not previously mentioned in this section.

In accordance with section 212 of the BBRA, we established a process to supplement the SMS data for a specialty with data collected by entities and organizations other than the AMA (that is, those entities and organizations representing the specialty itself). (See the Criteria for Submitting Supplemental Practice Expense Survey Data interim final rule with comment period (65 FR 25664).) Originally, the deadline to submit supplementary survey data was through August 1, 2001. In the CY 2002 PFS final rule (66 FR 55246), the deadline was extended through August 1, 2003. To ensure maximum opportunity for specialties to submit supplementary survey data, we extended the deadline to submit surveys until March 1, 2005 in the Revisions to Payment Policies Under the Physician Fee Schedule for CY 2004 final rule with comment period (68 FR 63196) (hereinafter referred to as CY 2004 PFS final rule with comment period).

The direct cost data for individual services were originally developed by the Clinical Practice Expert Panels (CPEP). The CPEP data include the supplies, equipment, and staff times specific to each procedure. The CPEPs consisted of panels of physicians, practice administrators, and nonphysicians (for example, RNs) who were nominated by physician specialty societies and other groups. There were 15 CPEPs consisting of 180 members from more than 61 specialties and subspecialties. Approximately 50 percent of the panelists were physicians.

The CPEPs identified specific inputs involved in each physician's service provided in an office or facility setting.

The inputs identified were the quantity and type of nonphysician labor, medical supplies, and medical equipment. The CPEP data has been regularly updated by various RUC committees on PE.

b. Allocation of PE to Services

The aggregate level specialty-specific PEs are derived from the AMA's SMS survey and supplementary survey data. To establish PE RVUs for specific services, it is necessary to establish the direct and indirect PE associated with each service.

(i) *Direct costs.* The direct costs are determined by adding the costs of the resources (that is, the clinical staff, equipment, and supplies) typically required to provide the service. The costs of these resources are calculated from the refined direct PE inputs in our PE database. These direct inputs are then scaled to the current aggregate pool of direct PE RVUs. The aggregate pool of direct PE RVUs can be derived using the following formula: (PE RVUs × physician CF) × (average direct percentage from SMS /(Supplemental PE/HR data)).

(ii) *Indirect costs.* The SMS and supplementary survey data are the source for the specialty-specific aggregate indirect costs used in our PE calculations. We then allocate the indirect costs to the code level on the basis of the direct costs specifically associated with a code and the greater of either the clinical labor costs or the physician work RVUs. For calculation of the 2010 PE RVUs, we use the 2008 procedure-specific utilization data crosswalked to 2010 services. To arrive at the indirect PE costs—

- We apply a specialty-specific indirect percentage factor to the direct expenses to recognize the varying proportion that indirect costs represent of total costs by specialty. For a given service, the specific indirect percentage factor to apply to the direct costs for the purpose of the indirect allocation is calculated as the weighted average of the ratio of the indirect to direct costs (based on the survey data) for the specialties that furnish the service. For example, if a service is furnished by a single specialty with indirect PEs that were 75 percent of total PEs, the indirect percentage factor to apply to the direct costs for the purposes of the indirect allocation would be (0.75/0.25) = 3.0. The indirect percentage factor is then applied to the service level adjusted indirect PE allocators.
- We use the specialty-specific PE/HR from the SMS survey data, as well as the supplemental surveys for cardiothoracic surgery, vascular surgery, physical and occupational therapy, independent laboratories, allergy/immunology, cardiology, dermatology, radiology, gastroenterology, IDTFs, radiation oncology, and urology. (**Note:** For radiation oncology, the data represent the combined survey data from the American Society for Therapeutic Radiology and Oncology (ASTRO) and the Association of Freestanding Radiation Oncology Centers (AFROC)). As discussed in the CY 2008 PFS final rule with comment period (72 FR 66233), the PE/HR survey data for radiology is weighted by practice size. We incorporate this PE/HR into the calculation of indirect costs using an index which reflects the relationship between each specialty's indirect scaling factor and the overall indirect scaling factor for the entire PFS. For example, if a specialty had an indirect practice cost index of 2.00, this specialty would have an indirect scaling factor that was twice the overall average indirect scaling factor. If a specialty had an indirect practice cost index of 0.50, this specialty would have an indirect scaling factor that was half the overall average indirect scaling factor.
- When the clinical labor portion of the direct PE RVU is greater than the physician work RVU for a particular service, the indirect costs are allocated based upon the direct costs and the clinical labor costs. For example, if a service has no physician work and 1.10 direct PE RVUs, and the clinical labor portion of the direct PE RVUs is 0.65 RVUs, we would use the 1.10 direct PE RVUs and the 0.65 clinical labor portions of the direct PE RVUs to allocate the indirect PE for that service.

c. Facility and Nonfacility Costs

Procedures that can be furnished in a physician's office, as well as in a hospital or facility setting have two PE RVUs: Facility and nonfacility. The nonfacility setting includes physicians' offices, patients' homes, freestanding imaging centers, and independent pathology labs. Facility settings include hospitals, ambulatory surgical centers (ASCs), and skilled nursing facilities (SNFs). The methodology for calculating PE RVUs is the same for both facility and nonfacility RVUs, but is applied independently to yield two separate PE RVUs. Because the PEs for services provided in a facility setting are generally included in the payment to the facility (rather than the payment to the physician under the PFS), the PE RVUs are generally lower for services provided in the facility setting.

d. Services With Technical Components (TCs) and Professional Components (PCs)

Diagnostic services are generally comprised of two components: A professional component (PC) and a technical component (TC), both of which may be performed independently or by different providers. When services have TCs, PCs, and global components that can be billed separately, the payment for the global component equals the sum of the payment for the TC and PC. This is a result of using a weighted average of the ratio of indirect to direct costs across all the specialties that furnish the global components, TCs, and PCs; that is, we apply the same weighted average indirect percentage factor to allocate indirect expenses to the global components, PCs, and TCs for a service. (The direct PE RVUs for the TC and PC sum to the global under the bottom-up methodology.)

e. Transition Period

As discussed in the CY 2007 PFS final rule with comment period (71 FR 69674), the change to the PE methodology was implemented over a 4-year period. In CY 2010, the transition period is concluded and PE RVUs will be calculated based entirely on the current methodology.

f. PE RVU Methodology

The following is a description of the PE RVU methodology.

(i) Setup File

First, we create a setup file for the PE methodology. The setup file contains the direct cost inputs, the utilization for each procedure code at the specialty and facility/nonfacility place of service level, and the specialty-specific survey PE per physician hour data.

(ii) Calculate the Direct Cost PE RVUs

Sum the Costs of Each Direct Input

Step 1: Sum the direct costs of the inputs for each service. The direct costs consist of the costs of the direct inputs for clinical labor, medical supplies, and medical equipment. The clinical labor cost is the sum of the cost of all the staff types associated with the service; it is the product of the time for each staff type and the wage rate for that staff type. The medical supplies cost is the sum of the supplies associated with the service; it is the product of the quantity of each supply and the cost of the supply. The medical equipment cost is the sum of the cost of the equipment associated with the service; it is the product of the number of minutes each piece of equipment is used in the

service and the equipment cost per minute. The equipment cost per minute is calculated as described at the end of this section.

Apply a BN Adjustment to the Direct Inputs

Step 2: Calculate the current aggregate pool of direct PE costs. To do this, multiply the current aggregate pool of total direct and indirect PE costs (that is, the current aggregate PE RVUs multiplied by the CF) by the average direct PE percentage from the SMS and supplementary specialty survey data.

Step 3: Calculate the aggregate pool of direct costs. To do this, for all PFS services, sum the product of the direct costs for each service from Step 1 and the utilization data for that service.

Step 4: Using the results of Step 2 and Step 3 calculate a direct PE BN adjustment so that the aggregate direct cost pool does not exceed the current aggregate direct cost pool and apply it to the direct costs from Step 1 for each service.

Step 5: Convert the results of Step 4 to an RVU scale for each service. To do this, divide the results of Step 4 by the Medicare PFS CF.

(iii) Create the indirect PE RVUs.

Create indirect allocators.

Step 6: Based on the SMS and supplementary specialty survey data, calculate direct and indirect PE percentages for each physician specialty.

Step 7: Calculate direct and indirect PE percentages at the service level by taking a weighted average of the results of Step 6 for the specialties that furnish the service. Note that for services with TCs and PCs, we are calculating the direct and indirect percentages across the global components, PCs, and TCs. That is, the direct and indirect percentages for a given service (for example, echocardiogram) do not vary by the PC, TC and global component.

Step 8: Calculate the service level allocators for the indirect PEs based on the percentages calculated in Step 7. The indirect PEs are allocated based on the three components: The direct PE RVU, the clinical PE RVU, and the work RVU.

For most services the indirect allocator is: *indirect percentage * (direct PE RVU/direct percentage) + work RVU.*

There are two situations where this formula is modified:

- If the service is a global service (that is, a service with global, professional, and technical components), then the indirect allocator is: *Indirect percentage * (direct PE RVU/direct percentage) + clinical PE RVU + work RVU.*
- If the clinical labor PE RVU exceeds the work RVU (and the service is not a global service), then the indirect allocator is: *Indirect percentage * (direct PE RVU/direct percentage) + clinical PE RVU.*

Note: For global services, the indirect allocator is based on both the work RVU and the clinical labor PE RVU. We do this to recognize that, for the professional service, indirect PEs will be allocated using the work RVUs, and for the TC service, indirect PEs will be allocated using the direct PE RVU and the clinical labor PE RVU. This also allows the global component RVUs to equal the sum of the PC and TC RVUs.

For presentation purposes in the examples in the Table 1, the formulas were divided into two parts for each service. The first part does not vary by service and is *the indirect percentage * (direct PE RVU/direct percentage).* The second part is either the work RVU, clinical PE RVU, or both depending on whether the service is a global service and whether the clinical PE RVU exceeds the work RVU (as described earlier in this step.)

Apply a BN Adjustment to the Indirect Allocators

Step 9: Calculate the current aggregate pool of indirect PE RVUs by multiplying the current aggregate pool of PE RVUs by the average indirect PE percentage from the physician specialty survey data. This is similar to the Step 2 calculation for the direct PE RVUs.

Step 10: Calculate an aggregate pool of indirect PE RVUs for all PFS services by adding the product of the indirect PE allocators for a service from Step 8 and the utilization data for that service. This is similar to the Step 3 calculation for the direct PE RVUs.

Step 11: Using the results of Step 9 and Step 10, calculate an indirect PE adjustment so that the aggregate indirect allocation does not exceed the available aggregate indirect PE RVUs and apply it to indirect allocators calculated in Step 8. This is similar to the Step 4 calculation for the direct PE RVUs.

Calculate the Indirect Practice Cost Index

Step 12: Using the results of Step 11, calculate aggregate pools of specialty-specific adjusted indirect PE allocators for all PFS services for a specialty by adding the product of the adjusted indirect PE allocator for each service and the utilization data for that service.

Step 13: Using the specialty-specific indirect PE/HR data, calculate specialty-specific aggregate pools of indirect PE for all PFS services for that specialty by adding the product of the indirect PE/HR for the specialty, the physician time for the service, and the specialty's utilization for the service.

Step 14: Using the results of Step 12 and Step 13, calculate the specialty-specific indirect PE scaling factors as under the current methodology.

Step 15: Using the results of Step 14, calculate an indirect practice cost index at the specialty level by dividing each specialty-specific indirect scaling factor by the average indirect scaling factor for the entire PFS.

Step 16: Calculate the indirect practice cost index at the service level to ensure the capture of all indirect costs. Calculate a weighted average of the practice cost index values for the specialties that furnish the service.

Note: For services with TCs and PCs, we calculate the indirect practice cost index across the global components, PCs, and TCs. Under this method, the indirect practice cost index for a given service (for example, echocardiogram) does not vary by the PC, TC and global component.

Step 17: Apply the service level indirect practice cost index calculated in Step 16 to the service level adjusted indirect allocators calculated in Step 11 to get the indirect PE RVU.

(iv) Calculate the Final PE RVUs

Step 18: Add the direct PE RVUs from Step 6 to the indirect PE RVUs from Step 17.

Step 19: Calculate and apply the final PE BN adjustment by comparing the results of Step 18 to the current pool of PE RVUs. This final BN adjustment is required primarily because certain specialties are excluded from the PE RVU calculation for ratesetting purposes, but all specialties are included for purposes of calculating the final BN adjustment. (*See* ''Specialties excluded from ratesetting calculation'' below in this section.)

(v) Setup File Information

- *Specialties excluded from ratesetting calculation:* For the purposes of calculating the PE RVUs, we exclude certain specialties such as midlevel practitioners paid at a percentage of the PFS, audiology, and low volume specialties from the calculation. These specialties *are* included for the purposes of calculating the BN adjustment.
- *Crosswalk certain low volume physician specialties:* Crosswalk the utilization of certain specialties with relatively low PFS utilization to the associated specialties.
- *Physical therapy utilization:* Crosswalk the utilization associated with all physical therapy services to the specialty of physical therapy.
- *Identify professional and technical services not identified under the usual*

TC and 26 modifiers: Flag the services that are PC and TC services, but do not use TC and 26 modifiers (for example, electrocardiograms). This flag associates the PC and TC with the associated global code for use in creating the indirect PE RVU. For example, the professional service code 93010 is associated with the global code 93000.

- *Payment modifiers:* Payment modifiers are accounted for in the creation of the file. For example, services billed with the assistant at surgery modifier are paid 16 percent of the PFS amount for that service; therefore, the utilization file is modified to only account for 16 percent of any service that contains the assistant at surgery modifier.
- *Work RVUs:* The setup file contains the work RVUs from this proposed rule.

(vi) Equipment cost per minute

The equipment cost per minute is calculated as:

*(1/(minutes per year * usage)) * price * ((interest rate/(1 − (1/((1 + interest rate) ** life of equipment)))) + maintenance)*

Where:

minutes per year = maximum minutes per year if usage were continuous (that is, usage = 1); 150,000 minutes.

usage = equipment utilization assumption; 0.9 for certain equipment (*see* section II.A.2. of this proposed rule) and 0.5. for others.

price = price of the particular piece of equipment.

interest rate = 0.11.

life of equipment = useful life of the particular piece of equipment.

maintenance = factor for maintenance; 0.05.

Note: To illustrate the PE calculation, in Table 1 we have used the conversion factor (CF) of $36.0666 which is the CF effective January 1, 2009 as published in CY 2009 PFS final rule with comment period.

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TABLE 1: Calculation of PE RVUs under Methodology for Selected Codes

		Step	Source	Formula	99213 Office visit, est Nonfacility	33533 CABG, arterial, single Facility	71020 Chest x-ray Nonfacility	71020TC Chest x-ray Nonfacility	7102026 Chest x-ray Nonfacility	93000 ECG, complete Nonfacility	93005 ECG, tracing Nonfacility	93010 ECG, report Nonfacility
(1)	Labor cost (Lab)	Step 1	AMA		$13.32	$77.52	$5.74	$5.74	$----	$6.12	$6.12	$----
(2)	Supply cost (Sup)	Step 1	AMA		$2.98	$7.34	$3.39	$3.39	$----	$1.19	$1.19	$----
(3)	Equipment cost (Eqp)	Step 1	AMA		$0.19	$0.65	$8.17	$8.17	$----	$0.12	$0.12	$----
(4)	Direct cost (Dir)	Step 1		=(1)+(2)+(3)	$16.50	$85.51	$17.31	$17.31	$----	$7.43	$7.43	$----
(5)	Direct adjustment (Dir Adj)	Steps 2-4	See footnote*		0.508	0.508	0.508	0.508	0.508	0.508	0.508	0.508
(6)	Adjusted labor	Steps 2-4	=Lab*Dir Adj	=(1)*(5)	$6.76	$39.35	$2.91	$2.91	$----	$3.11	$3.11	$----
(7)	Adjusted supplies	Steps 2-4	=Sup*Dir Adj	=(2)*(5)	$1.51	$3.73	$1.72	$1.72	$----	$0.61	$0.61	$----
(8)	Adjusted equipment	Steps 2-4	=Eqp*Dir Adj	=(3)*(5)	$0.10	$0.33	$4.15	$4.15	$----	$0.06	$0.06	$----
(9)	Adjusted direct	Steps 2-4		=(6)+(7)+(8)	$8.38	$43.41	$8.79	$8.79	$----	$3.77	$3.77	$----
(10)	Conversion Factor (CF)	Step 5	MFS		36.0666	36.0666	36.0666	36.0666	36.0666	36.0666	36.0666	36.0666
(11)	Adj. labor cost converted	Step 5	=(Lab*Dir Adj)/CF	=(6)/(10)	0.19	1.09	0.08	0.08		0.09	0.09	
(12)	Adj. supply cost converted	Step 5	=(Sup*Dir Adj)/CF	=(7)/(10)	0.04	0.10	0.05	0.05		0.02	0.02	
(13)	Adj. equip cost converted	Step 5	=(Eqp*Dir Adj)/CF	=(8)/(10)	0.00	0.01	0.12	0.12		0.00	0.00	
(14)	Adj. direct cost converted	Step 5		=(11)+(12)+(13)	0.23	1.20	0.24	0.24		0.10	0.10	
(15)	Wrk RVU	Setup File	MFS		0.97	33.64	0.22		0.22	0.17		0.17
(16)	Dir pct	Steps 6, 7	Surveys		25.6%	18.0%	28.5%	28.5%	28.5%	28.8%	28.8%	28.8%
(17)	Ind pct	Steps 6, 7	Surveys		74.4%	82.0%	71.5%	71.5%	71.5%	71.2%	71.2%	71.2%
(18)	Ind. Alloc. formula (1st part)	Step 8	See Step 8		((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)
(19)	Ind. Alloc. (1st part)	Step 8		See (18)	0.68	5.48	0.61	0.61		0.26	0.26	
(20)	Ind. Alloc. formulas (2nd part)	Step 8	See Step 8		(15)	(15)	(15)+(11)	(11)	(15)	(15)+(11)	(11)	(15)
(21)	Ind. Alloc. (2nd part)	Step 8		See (20)	0.97	33.64	0.30	0.08	0.22	0.26	0.11	0.17
(22)	Indirect Allocator (1st+2nd)	Step 8		=(19)+(21)	1.65	39.12	0.91	0.69	0.22	0.51	0.37	0.17
(23)	Indirect Adjustment (Ind Adj)	Steps 9-11	See footnote**		0.367	0.367	0.367	0.367	0.367	0.367	0.367	0.367
(24)	Adjusted Indirect Allocator	Steps 9-11	=Ind Alloc * Ind Adj		0.60	14.35	0.33	0.25	0.08	0.19	0.14	0.06
(25)	Ind .Practice Cost Index (PCI)	Steps 12-16	See Steps 12-16		1.094	0.901	0.846	0.846	0.846	0.929	0.929	0.929
(26)	Adjusted Indirect	Step 17	= Adj. Ind Alloc*PCI	=(24)*(25)	0.66	12.92	0.28	0.22	0.07	0.18	0.13	0.06
(27)	PE RVU	Steps 18-19	=(Adj Dir+Adj Ind) *budn	=((14)+(26)) *budn	0.89	14.07	0.52	0.46	0.07	0.28	0.23	0.06

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Note: Proposed PE RVU in Table 1, row 27, may not match Addendum B due to rounding.

* The direct adj = [current PE RVUs * CF * avg dir pct] / [sum direct inputs] = [Step 2] / [Step 3]

** The indirect adj = [current PE RVUs * avg ind pct] / [sum of ind allocators] = [Step 9] / [Step 10]

2. PE Proposals for CY 2010

a. SMS and Supplemental Survey Background

Currently, we use PE/HR obtained from the SMS surveys from 1995–1999. For several specialties that collected additional PE/HR data through a more recent supplemental survey, we accepted and incorporated these data in developing current PE/HR values.

While the SMS survey was not specifically designed for the purpose of establishing PE RVUs, we found these data to be the best available at the time. The SMS was a multi-specialty survey effort conducted using a consistent survey instrument and method across specialties. The survey sample was randomly drawn from the AMA Physician Masterfile to ensure national representativeness. The AMA discontinued the SMS survey in 1999.

As required by the BBRA, we also established a process by which specialty groups could submit supplemental PE data. In the May 3, 2000 interim final rule entitled, Medicare Program; Criteria for Submitting Supplemental Practice Expense Survey Data, (65 FR 25664), we established criteria for acceptance of supplemental data. The criteria were modified in the CY 2001 and CY 2003 PFS final rules with comment period (65 FR 65380 and 67 FR 79971, respectively). We currently use supplemental survey data for the following specialties: Cardiology; dermatology; gastroenterology; radiology; cardiothoracic surgery; vascular surgery; physical and occupational therapy; independent laboratories; allergy/immunology; independent diagnostic testing facilities (IDTFs); radiation oncology; medical oncology; and urology.

Because the SMS data and the supplemental survey data are from different time periods, we have historically inflated them by the MEI to help put them on as comparable a time basis as we can when calculating the PE RVUs. This MEI proxy has been necessary in the past due to the lack of contemporaneous, consistently collected, and comprehensive multispecialty survey data.

b. Physician Practice Information Survey (PPIS)

The AMA has conducted a new survey, the PPIS, which was expanded (relative to the SMS) to include nonphysician practitioners (NPPs) paid under the PFS. The PPIS, administered in CY 2007 and CY 2008, was designed to update the specialty-specific PE/HR data used to develop PE RVUs.

The AMA and our contractor, The Lewin Group (Lewin), analyzed the PPIS data and calculated the PE/HR for physician and nonphysician specialties, respectively. The AMA's summary worksheets and Lewin's final report are available on the CMS Web site at *http://www.cms.gov/PhysicianFeeSched/*. (*See* AMA PPIS Worksheets 1–3 and Lewin Group Final Report PPIS.) Table 2 shows the current indirect PE/HR based on SMS and supplemental surveys, the PPIS indirect PE/HR, and the indirect cost percentages of total costs.

TABLE 2—INDIRECT PE/HR AND INDIRECT PERCENTAGES

[Current and PPIS]

Specialty	Current indirect PE/HR	PPIS indirect PE/HR	Current indirect %	PPIS indirect %	Current crosswalk
All Physicians.	$59.04	$86.36	67	74	
Allergy and Immunology	153.29	162.68	62	67	
Anesthesiology	19.76	29.37	56	82	
Audiology	59.04	72.17	67	85	All Physicians.
Cardiology	131.02	88.04	56	65	
Cardiothoracic Surgery	61.75	67.83	68	83	
Chiropractor	49.60	65.33	69	86	Internal Medicine.
Clinical Laboratory (Billing Independently) *	66.46	71.01	37	37	
Clinical Psychology	29.07	20.07	90	93	Psychiatry.
Clinical Social Work	29.07	17.80	90	97	Psychiatry.
Colon & Rectal Surgery	53.93	90.85	77	80	
Dermatology	158.49	184.62	70	70	
Emergency Medicine	36.85	38.36	88	94	
Endocrinology	49.60	84.39	69	73	
Family Medicine	52.79	90.15	62	76	
Gastroenterology	101.30	96.78	70	75	
General Practice	52.79	78.59	62	69	
General Surgery	53.93	82.74	77	82	
Geriatrics	49.60	54.14	69	74	
Hand Surgery	98.56	148.78	72	77	
Independent Diagnostic Testing Facilities *	466.16	501.45	50	50	
Internal Medicine	49.60	84.03	69	76	
Interventional Pain Medicine	59.04	156.79	67	70	
Interventional Radiology	118.48	82.55	58	81	
Medical Oncology	141.84	129.94	59	56	
Nephrology	49.60	66.00	69	80	
Neurology	66.05	110.39	74	87	
Neurosurgery	89.64	115.76	86	87	
Nuclear Medicine	118.48	39.80	58	77	
Obstetrics/Gynecology	69.74	99.32	67	67	
Ophthalmology	103.28	170.08	65	70	
Optometry	59.04	88.02	67	77	All Physicians.
Oral Surgery (Dentist only)	96.01	173.19	71	65	Otolaryngology.

TABLE 2—INDIRECT PE/HR AND INDIRECT PERCENTAGES—Continued

[Current and PPIS]

Specialty	Current indirect PE/HR	PPIS indirect PE/HR	Current indirect %	PPIS indirect %	Current crosswalk
Orthopaedic Surgery	98.56	131.40	72	81	
Osteopathic Manipulative Therapy	59.04	53.93	67	93	
Otolaryngology	96.01	141.53	71	75	
Pain Medicine	59.04	122.41	67	70	
Pathology	59.80	74.98	70	74	
Pediatrics	51.52	76.27	62	69	
Physical Medicine and Rehabilitation	84.92	110.13	71	84	
Physical Therapy	35.17	57.26	65	84	
Plastic Surgery	99.32	134.82	67	74	
Podiatry	59.04	74.76	67	82	All Physicians.
Psychiatry	29.07	30.09	90	94	
Pulmonary Disease	44.63	55.26	76	74	
Radiation Oncology (Hospital Based & Freestanding)	114.00	126.66	50	56	
Radiology	118.48	95.60	58	71	
Registered Dieticians	59.04	18.45	67	84	All Physicians.
Rheumatology	84.92	98.08	71	67	
Urology	119.57	97.02	69	73	
Vascular Surgery	60.10	83.98	63	73	

* Did not participate in PPIS. Data based on Supplemental Survey.

The PPIS is a multispecialty, nationally representative, PE survey of both physician and NPPs using a consistent survey instrument and methods highly consistent with those used for the SMS and the supplemental surveys. The PPIS has gathered information from 3,656 respondents across 51 physician specialty and health care professional groups. We believe the PPIS is the most comprehensive source of PE survey information available to date.

As noted, the BBRA required us to establish criteria for accepting supplemental survey data. Since the supplemental surveys were specific to individual specialties and not part of a comprehensive multispecialty survey, we had required certain precision levels be met in order to ensure that the supplemental data was sufficiently valid, and to be accepted for use in the development of the PE RVUs. Because the PPIS is a contemporaneous, consistently collected, and comprehensive multispecialty survey, we do not believe similar precision requirements are necessary and are not proposing to establish them for the use of the PPIS data.

For physician specialties, the survey responses were adjusted for non-response bias. Non-response bias is the bias that results when the characteristics of survey respondents differ in meaningful ways, such as in the mix of practice sizes, from the general population. The non-response adjustment was developed based on a comparison of practice size and other characteristic information between the PPIS survey respondents and data from the AMA Masterfile (for physician specialties) or information from specialty societies (for non-physician specialties). For six specialties (that is, chiropractors, clinical social workers, nuclear medicine, osteopathic manipulative therapy, physical therapy, and registered dietians) such an adjustment was not possible due to a lack of available characteristic data. The AMA and Lewin have indicated that the non-response weighting has only a small impact on PE/HR values.

Under our current policy, various specialties without SMS or supplemental survey data have been crosswalked to other similar specialties to obtain a proxy PE/HR. For specialties that were part of the PPIS for which we currently use a crosswalked PE/HR, we are proposing instead to use the PPIS-based PE/HR. We are proposing to continue current crosswalks for specialties that did not participate in PPIS.

Supplemental survey data on independent labs, from the College of American Pathologists, was implemented for payments in CY 2005. Supplemental survey data from the National Coalition of Quality Diagnostic Imaging Services (NCQDIS), representing IDTFs, was blended with supplementary survey data from the American College of Radiology (ACR) and implemented for payments in CY 2007. Neither IDTFs nor Independent Labs participated in PPIS. Therefore, we are proposing to continue using the current PE/HR that was developed using their supplemental survey data.

We are not proposing to use the PPIS data for reproductive endocrinology, sleep medicine, and spine surgery since these specialties are not separately recognized by Medicare and we do not know how to blend this data with the Medicare recognized specialty data. We seek comment on this issue.

We are not proposing changes to the manner in which the PE/HR data are used in the current PE RVU methodology. We are merely proposing to update the PE/HR data itself based on the new survey. We propose to utilize the PE/HR developed using PPIS data for all Medicare recognized specialties that participated in the PPIS for payments effective January 1, 2010. The impact of using the new PPIS-based PE/HR is discussed in the Regulatory Impact Analysis in section V. of this proposed rule.

c. Equipment Utilization Rate

As part of the PE methodology associated with the allocation of equipment costs for calculating PE RVUs, we have adopted an equipment usage assumption of 50 percent. Most recently, we included a discussion in the CY 2008 PFS proposed rule on this equipment usage assumption (72 FR 38132). We noted that if the assumed equipment usage percentage is set too high, the result would be an insufficient allowance at the service level for the practice costs associated with equipment. If the assumed equipment usage percentage is set too low, the result would be an excessive allowance for the practice costs of equipment at the service level. We acknowledged that

the current 50 percent usage assumption does not capture the actual usage rates for all equipment, but stated that we did not believe that we had strong empirical evidence to justify any alternative approaches.

The commenters' recommendations about making adjustments to the 50 percent utilization rate assumption varied. Certain commenters recommended we do nothing until stronger empirical evidence is available, while other commenters recommended a decrease in the utilization assumption, and some commenters recommended an increase in the utilization assumption. The particular changes recommended in the utilization assumption were, in most cases, directly related to a specific code.

In the CY 2008 PFS final rule with comment period (72 FR 66232), we agreed with commenters that the equipment utilization rate should continue to be examined for accuracy. We reiterated our commitment to continue to work with interested parties on this issue. We indicated that we would continue to monitor the appropriateness of the equipment utilization assumption, and evaluate whether changes should be proposed in light of the data available.

Since the publication of the CY 2008 PFS final rule with comment period, MedPAC addressed this issue again in its March 2009 Report to Congress (*see http://www.medpac.gov/documents/Mar09_EntireReport.pdf*). In part of its discussion, MedPAC stated:

''In 2006, the Commission sponsored a survey by NORC of imaging providers in six markets, which found that MRI and CT machines are used much more than the 25 hours per week that CMS assumes (Table 2B–6). According to data from this survey, MRI scanners are used 52 hours per week, on average (median of 46 hours), and CT machines are operated 42 hours per week, on average (median of 40 hours) (NORC 2006).[32] Although the survey results are not nationally representative, they are representative of imaging providers in the six markets included in the survey. We also analyzed data from a 2007 survey of CT providers by IMV, a market research firm (IMV Medical Information Division 2008). IMV data are widely used in the industry and have also appeared in published studies (Baker *et al.* 2008, Baker and Atlas 2004). Using IMV's data on 803 nonhospital CT providers (imaging centers, clinics, and physician offices), we calculated that the average provider uses its CT scanner 50 hours per week, which is twice the number CMS assumes.[33] The IMV survey also found that nonhospital providers increased the average number of procedures per CT machine by 31 percent from 2003 to 2007, which indicates that providers either used their machines more hours per day or performed more scans per hour (IMV Medical Information Division 2008).'' (p. 108)

We believe the studies cited by MedPAC strongly suggest that our current usage rate assumption is significantly understated, especially with respect to the types of high cost equipment that were the subject of the studies. Our current 50 percent utilization rate translates into about 25 hours per week out of a 50 hour work week. The median value of 46 hours for MRIs from the first study cited by MedPAC is equivalent to a utilization rate of 92 percent on a 50-hour week. For CT scanners, averaging the value from the first study of 40 hours per week and the value from the second study of 50 hours per week yields 45 hours and is equivalent to a 90 percent utilization rate on a 50 hour work week. We believe the studies cited by MedPAC suggest what we have long suspected, that physicians and suppliers would not typically make huge capital investments in equipment that would only be utilized 50 percent of the time. All of the equipment cited in the MedPAC studies is priced over $1 million. Therefore, we are proposing to change the equipment usage assumption from the current 50 percent usage rate to a 90 percent usage rate for equipment priced over $1 million. We will continue to explore data sources regarding the utilization rates of equipment priced at less than $1 million dollars, but are not proposing a change in the usage rate for this less expensive equipment at this time.

As MedPAC indicated in its report, we do not believe this proposal would create access issues in rural areas. MedPAC noted,

''According to our analysis of data from the American Hospital Association's 2006 AHA annual survey of hospitals, 95% of rural hospitals provide CT services in their community (AHA 2007). Therefore, if rural areas do not have physician offices or freestanding centers with MRI and CT machines, most of these communities have access to such services through a hospital.'' (p. 110)

However, we welcome any additional analyses regarding access issues, and, as in our CY 2008 and CY 2009 rulemaking, we welcome additional empirical data relating to equipment utilization rates. Our understanding is that the PPIS survey did not produce information that can inform the utilization rate discussion, but we invite comments on this or other data sources.

d. Miscellaneous PE Issues

As we have discussed in the past rulemaking (*see* the CY 2008 PFS final rule with comment period (72 FR 66236) and the CY 2007 PFS final rule with comment period (71 FR 69647)), we continue to have concerns about the issue of PE RVUs for services which are utilized 24 hours a day/7 days a week, such as certain monitoring systems. For example, the PE equipment methodology was not developed with this type of 24/7 equipment in mind. We are continuing to analyze the issue of PEs for services which are utilized 24 hours a day/7 days a week to identify any modifications to our methodology that would address the specific ''constant use'' issues associated with these services. Services that are currently contractor priced in CY 2009 would remain contractor priced in CY 2010. Any proposed changes will be communicated through future rulemaking.

We also received comments regarding the PE direct cost inputs (for example, supply costs and the useful life of the renewable sources) related to several high dose radiation therapy (HDRT) and placement CPT codes. Based on our review of these codes and comments received, we are requesting that the AMA RUC consider these CPT codes for additional review.

e. AMA RUC Recommendations for Direct PE Inputs

The AMA RUC provided recommendations for PE inputs for the codes listed in Table 3.

TABLE 3—CODES WITH AMA RUC PE RECOMMENDATIONS

CPT[1] code	Description
37183 ...	Remove hepatic shunt (tips).
47382 ...	Percut ablate liver rf.
50200 ...	Biopsy of kidney.
55873 ...	Cryoablate prostate.
93025 ...	Microvolt t-wave assess.

[1] CPT codes and descriptions are Copyright 2009 American Medical Association.

We are in agreement with the AMA RUC recommendations for the direct PE inputs for the codes listed in Table 3 and propose to adopt these for CY 2010.

B. Geographic Practice Cost Indices (GPCIs): Locality Discussion

1. Update—Expiration of 1.0 Work GPCI Floor

Section 1848(e)(1)(A) of the Act requires us to develop separate Geographic Practice Cost Indices (GPCIs) to measure resource cost differences among localities compared to the national average for each of the three fee schedule components (that is, work, PE and malpractice). While requiring that the PE and malpractice GPCIs reflect the full relative cost differences, section 1848(e)(1)(A)(iii) of

the Act requires that the physician work GPCIs reflect only one-quarter of the relative cost differences compared to the national average.

Section 1848(e)(1)(C) of the Act requires us to review and, if necessary, adjust the GPCIs at least every 3 years. This section also specifies that if more than 1 year has elapsed since the last GPCI revision, we must phase in the adjustment over 2 years, applying only one-half of any adjustment in each year. As discussed in the CY 2009 PFS final rule with comment period (73 FR 69740), the CY 2009 adjustment to the GPCIs reflected the fully implemented fifth comprehensive GPCI update. We also noted that section 134 of the MIPPA extended the 1.000 work GPCI floor from July 1, 2008, through December 31, 2009. (**Note:** The 1.000 work GPCI floor was enacted and implemented for CY 2006, and, prior to enactment of the MIPPA, was set to expire on June 30, 2008.) Additionally, section 1848(e)(1)(G) of the Act, as amended by section 134(b) of the MIPPA, set a permanent 1.5 work GPCI floor in Alaska for services furnished beginning January 1, 2009. Therefore, as required by the MIPPA, beginning on January 1, 2010, the 1.000 work GPCI floor will be removed. However, the 1.500 work GPCI floor for Alaska will remain in place. *See* Addenda D and E of this proposed rule for the GPCIs and summarized geographic adjustment factors (GAFs), respectively.

2. Payment Localities

a. Background

As stated above in this section, section 1848(e)(1)(A) of the Act requires us to develop separate GPCIs to measure resource cost differences among localities compared to the national average for each of the three fee schedule components (this is, work, PE, and malpractice). Payments under the PFS are based on the relative resources involved in furnishing physicians' services, and are adjusted for differences in relative resource costs among payment localities using the GPCIs. As a result, PFS payments vary between localities.

The current PFS locality structure was developed and implemented in 1997. There are currently 89 localities including 37 higher-cost areas; 16 Rest of State areas (comprising the remaining counties not located in a higher-cost area within a State); 34 Statewide areas; and Puerto Rico and the Virgin Islands which are designated as ''territory-wide'' localities. The development of the current locality structure is described in detail in the CY 1997 PFS proposed rule (61 FR 34615) and the subsequent final rule (61 FR 59494).

As we have frequently noted, any changes to the locality configuration must be made in a budget neutral manner. Therefore, any change in localities can lead to significant redistributions in payments. For many years, we have not considered making changes to localities without the support of a State medical association in order to demonstrate consensus for the change among the professionals whose payments would be affected (with some increasing and some decreasing). However, we have recognized that, over time, changes in demographics or local economic conditions may lead us to conduct a more comprehensive examination of existing payment localities.

Payment Locality Approaches Discussed in the CY 2008 PFS Proposed Rule

For the past several years, we have been involved in discussions with California physicians and their representatives about recent shifts in relative demographics and economic conditions among a number of counties within the current California payment locality structure. In the CY 2008 PFS proposed rule and final rule with comment period, we described three potential options for changing the payment localities in California (72 FR 38139 and 72 FR 66245, respectively).

After reviewing the comments on these options, we decided not to proceed with implementing any of them at that time. We explained that there was no consensus among the California medical community as to which, if any, of the options would be most acceptable. We also received suggestions from the Medicare Payment Advisory Commission (MedPAC) for developing changes in payment localities for the entire country and other States expressed interest in having their payment localities reconfigured as well. In addition, other commenters wanted us to consider a national reconfiguration of localities rather than just making changes one State at a time. Because of the divergent views expressed in comments, we explained in the CY 2008 PFS final rule with comment period that we intended to conduct a thorough analysis of potential approaches to reconfiguring localities and would address this issue again in future rulemaking.

Interim Study of Alternative Payment Localities Under the PFS

As a follow-up to the CY 2008 PFS final rule with comment period, we contracted with Acumen, LLC (Acumen), to conduct a preliminary study of several options for revising the payment localities on a nationwide basis. The contractor's interim report was posted on the CMS Web site on August 21, 2008, and we requested comments from the public. The report entitled, ''Review of Alternative GPCI Payment Locality Structures,'' is still accessible from the CMS PFS Web page under the heading ''Interim Study of Alternative Payment Localities under the PFS.'' The report may also be accessed directly from the following link: *http://www.cms.hhs.gov/PhysicianFeeSched/10_Interim_Study.asp#TopOfPage*. We accepted comments on the interim report through November 3, 2008. The alternative locality configurations discussed in the report are described briefly below in this section.

Option 1: CMS Core Based Statistical Area (CBSA) Payment Locality Configuration

This option uses the Office of Management and Budget (OMB's) Metropolitan Statistical Area (MSA) designations for the payment locality configuration. MSAs would be considered as urban CBSAs. Micropolitan Areas (as defined by OMB) and rural areas would be considered as non-urban (rest of State) CBSAs. This approach would be consistent with the inpatient hospital prospective payment system (IPPS) pre-reclassification CBSA assignments and with the geographic payment adjustments used in other Medicare payment systems. This option would increase the number of localities from 89 to 439.

Option 2: Separate High Cost Counties From Existing Localities (Separate Counties)

Under this approach, higher cost counties are removed from their existing locality structure and they would each be placed into their own locality. This option would increase the number of localities from 89 to 214 using a 5 percent GAF differential to separate high cost counties.

Option 3: Separate MSAs From Statewide Localities (Separate MSAs)

This option begins with Statewide localities and creates separate localities for higher cost MSAs (rather than removing higher cost counties from their existing locality as described in option 2). This option would increase the number of localities from 89 to 130 using a 5 percent GAF differential to separate high cost MSAs.

Option 4: Group Counties Within a State Into Locality Tiers Based on Costs (Statewide Tiers)

This option creates tiers of counties (within each State) that may or may not be contiguous but share similar practice costs. This option would increase the number of localities from 89 to 140 using a 5 percent GAF differential to group similar counties into Statewide tiers.

Additionally, as discussed in the interim locality study report, our contractor, Acumen, applied a ''smoothing'' adjustment to the current PFS locality structure, as well as to each of the alternative locality configurations (except option 4: Statewide Tiers). The ''smoothing'' adjustment was applied to mitigate large payment differences (or payment ''cliffs'') between adjacent counties. Since large payment differences between adjacent counties could influence a physician's decision on a practice location (and possibly impact access to care), the ''smoothing'' adjustment was applied to ensure that GAF differences between adjacent counties do not exceed 10 percent. (For more information on the ''smoothing'' adjustment *see* the interim locality study report on the PFS Web page via the link provided above.)

b. Summary of Public Comments on Interim Locality Study Report

In the CY 2009 PFS proposed rule (73 FR 38514), we encouraged interested parties to submit comments on the options presented both in the proposed rule and in the interim report posted on our Web site. We also requested comments and suggestions on other potential alternative locality configurations (in addition to the options described in the report). Additionally, we requested comments on the administrative and operational issues associated with the various options under consideration. We also emphasized that we would not be proposing any changes to the current PFS locality structure for CY 2009 and that we would provide extensive opportunities for public comment before proposing any change. The following is a summary of the comments received on the alternative locality options discussed in the CY 2009 PFS proposed rule and interim locality study report.

(1) Introduction and General Support for Change

We received approximately 200 comments on the CY 2009 PFS proposed rule and locality study report from various specialty groups, medical societies, State medical associations, individual practitioners, and beneficiaries. Commenters generally commended us for acknowledging the need to reconfigure PFS payment localities and expressed support for our study of alternative locality configurations. Many commenters urged us to expedite changes to the current locality structure in order to accurately reflect the geographic cost differences of operating a medical practice. For example, the Connecticut State Medical Society commented that the current locality configuration contributes to medical access issues and problems with recruitment and retention of practitioners (with an emphasis on access to primary care).

Another commenter stated that Ohio's Statewide locality configuration needs to be changed because a Statewide locality designation does not account for the (presumably higher) cost of operating a medical practice in northern Ohio. The commenter also objected to the agency's approach to requests for changes to the current locality structure (which includes an assessment of support for the changes by the medical community, including the relevant State medical associations). The commenter believes the State medical association does not represent all of the physicians in Ohio.

Another commenter stated that a change in the PFS locality structure is long overdue. The commenter stated that San Diego County is the most underpaid area in the nation and that grouping that county with the Rest of California locality is erroneous. Moreover, several commenters stated that a timely reassessment is needed and urged us to update the locality structure every 3 years. Two commenters believe that previous studies completed on the PFS locality structure by MedPAC, GAO, Urban Institute, as well as the current study by Acumen, support immediate reform to the current PFS locality structure.

We received many comments from hospitals and physicians located in Frederick County Maryland (which is currently grouped with the Rest of Maryland locality). The commenters support each of the alternative locality configurations we presented because each option results in PFS payment increases for services furnished in Frederick County. The commenters stated that Frederick County is considered a 'bedroom community' for the DC/Northern Virginia area, has experienced the highest growth rate in the State, and noted that the cost of living has increased significantly. Additionally, the commenters noted that the last economic census aligns costs in Frederick County with those in Montgomery County (whose doctors receive higher payment amounts) and that Frederick County competes with physician practices in Montgomery County for professional staff. Moreover, the commenters believe that because of inadequate PFS payment amounts, access to care is becoming a problem and emergency room visits are on the rise.

(2) Cautious Approach

Some commenters requested that we take a cautious approach to reconfiguring the locality structure. For instance, the Texas Medical Association stated that because of the redistributive impact that results from any locality reconfiguration, CMS should avoid making large scale changes at one time. Additionally, another commenter stated that ''stakeholders'' should be given a long advance notification period (at least 2 full calendar years) prior to the effective date of any changes to the PFS locality configuration. The commenter also stated that the current locality structure should remain in place (for each locality) unless the need for revision is strongly substantiated because of a change in practice cost patterns. A specialty society expressed support for postponing any adjustments for at least 1 year to allow for more discussion between CMS and ''stakeholders''.

(3) Guiding Principles

We received several comments from California that suggested a set of goals for reforming the PFS payment locality structure. The goals suggested by the commenters are as follows:

- Improve payment accuracy (as compared to the current locality structure);
- Move towards MSA-based localities;
- Mitigate payment reductions to rural California areas (and therefore minimize corresponding negative impact on access to care in California); and
- Promote administrative simplification by aligning physician and hospital payment localities.

The California Medical Association (CMA) urged us to apply a consistent methodology across all payment localities and requested that any revision to the localities include a ''formula driven'' mechanism that can be applied repeatedly to future revisions. A California county medical society stated that more specific objectives for reforming PFS payment localities should be developed. For example, the commenter suggested that

payment reductions for practitioners should not exceed 1.5 percent in any given year, GAF differentials between adjacent localities should not exceed 10 percent, and that contiguous localities with less than a 1 percent difference in their GAF's should be combined into a single locality.

(4) Comments on the Studied Alternative Locality Options

We received many comments on the options for reconfiguring PFS payment localities presented in the interim locality study report. One commenter stated that option 1 (the CMS CBSA locality configuration) is the best option because it provides the greatest payment accuracy. The same commenter also stated that using CBSAs as the PFS locality definition would be similar to other Medicare payment systems (for example, the IPPS). Therefore, the commenter believed that geographic payment adjustments for physicians and hospitals would be consistent for a given geographic area. The CMA and a California county medical society stated that although option 1 would provide the greatest payment accuracy, it would also lead to significant payment reductions for many counties. Those same commenters expressed concern with the negative impact of transitioning directly to the CMS CBSA locality configuration. If adopted, the commenters suggested that the CMS CBSA locality configuration be implemented in stages over several years. The Texas Medical Association echoed this concern and urged us not to adopt option 1 unless we employ a hold harmless floor along with ''material'' increases in the conversion factor.

The Texas Medical Association also stated that option 2 (Separate High Cost Counties from Existing Localities) results in less significant payment reductions to rural practitioners, as compared to the reductions seen under option 1 (CMS CBSA) and option 4 (Statewide Tiers). However, the commenter did not support option 2 because it would create different localities within major urban areas and, therefore, provide incentives for ''border-crossing,'' (in other words, incentives for physicians to move their medical practice to an adjacent urbanized county to obtain a higher payment amount). Additionally, the Texas Medical Association stated that option 2 increases administrative complexity due to the additional number of localities and the need to reallocate source data into smaller (county level) areas. The CMA also stated that option 2 results in less significant payment reductions (as compared to the other options). However, the CMA stated that option 2 continues to produce inaccurate payments because it applies MSA-based data to county-based localities.

Many commenters from the State of California expressed support for option 3 (Separate High Cost MSAs from Statewide Localities) because the commenters believed it would improve payment accuracy (over the current locality configuration) and at the same time mitigate the payment reductions to rural areas that would occur under option 1 (CMS CBSA) and option 4 (Statewide Tiers). The CMA explained that selecting an MSA-based locality approach would provide consistency with the hospital payment system and enable physicians to better compete with hospitals for the local work force. For example, the commenters stated that hospitals located in the Santa Cruz MSA are some of the highest paid in the nation. However, under the PFS locality structure, Santa Cruz County is grouped with the Rest of California locality, which is the lowest paid PFS locality in the State.

The Texas Medical Association suggested that we adopt option 3 because it minimizes payment reductions to lower cost rural areas. For example, since option 3 results in the fewest payment localities (as compared to the other alternative locality configurations), it reduces the redistribution effects of separating higher cost areas from rural ''rest of State'' areas. The commenter also stated that option 3 (Separate MSAs) matches payment with the underlying data better than option 2 (Separate Counties) and option 4 (Statewide Tiers). Some commenters expressed their belief that MSAs are better basic locality units than counties because the cost data is more reliably derived directly from MSAs (instead of counties). Several commenters who supported the adoption of an MSA-based PFS locality structure suggested that option 3 could be used as a transition to the CMS CBSA locality configuration (option 1).

With regard to option 4 (Statewide Tiers), the Texas Medical Association stated that the Statewide Tiers locality configuration creates payment areas that are poorly aligned with the underlying data and results in unacceptable payment decreases to small urban and rural areas. The Florida Medical Association explained that many localities have experienced a shift in population and economic development since the last PFS locality reconfiguration. The commenter stated that counties with similar costs should be grouped together in the same locality regardless of geographic location and that the Statewide cost tier locality structure (option 4) would accomplish this objective. The CMA stated that under option 4, counties are not geographically contiguous and noted that the counties grouped together in a locality may not be related to one another economically. The commenter suggested that noncontiguous counties may experience more frequent economic changes than contiguous counties. The commenter expressed concern that option 4 would need to be updated more frequently and therefore payments to physicians will fluctuate more often. A California county medical society stated that option 4 creates payment errors for counties in seven California localities that currently have accurate payments. The Connecticut State Medical Society stated that New Haven County would experience an increase under option 4.

(5) Smoothing Adjustment

Many commenters from the State of California did not support the concept of ''smoothing'' because it would require payment reductions for higher cost counties to offset the increases given to lower cost counties (in order to achieve budget neutrality). Additionally, the same commenters stated that physicians in ''smoothed'' counties benefit financially from the smoothing adjustment solely because they are located adjacent to high cost areas. They also stated that a ''smoothing'' adjustment would be complex to administer, and difficult to understand. The CMA, a California county medical society, and another commenter from California stated that a ''smoothing'' adjustment would require a change in the statute and that current Medicare statute requires GPCIs to reflect the relative costs differences among localities for work, PE, and malpractice expense. Another commenter recommended that we study the extent to which a ''smoothing'' adjustment can be used as a temporary measure; in order to phase-in significant changes in payment levels resulting from a PFS locality reconfiguration.

(6) Other Alternative Options

A few commenters submitted suggestions on other potential alternative PFS locality configurations in addition to those discussed in the interim report. For example, one medical clinic suggested a ''market-based'' approach instead of the current ''cost-based'' methodology. Under this approach, PFS payment would be geographically adjusted based on the ratio of Medicare participating

physicians to Medicare beneficiaries. The commenter suggested that payment amounts should be increased in geographic areas with a low physician to Medicare beneficiary ratio (for example, 1 physician for every 3,000 beneficiaries) and decreased in areas with a higher ratio (for example, 1 physician for every 200 beneficiaries). The commenter stated that ''this process could be used to bring physician to patient ratios in the United States to equilibrium.''

The CMA and a California county medical society suggested variations of option 2 (Separate Counties) with the intention of reducing the number of localities that would result under this option. The commenters suggested adopting a ''basic locality unit'' (for example, MSA) instead of a county when removing areas from an existing locality. For example, if 5 counties are removed from a ''Rest of State'' locality, and included within the same MSA, the 5 counties would be grouped into a single new locality rather than 5 separate new localities. The commenter also suggested that if removed counties are contiguous and have similar costs (even if not part of same MSA); they should be consolidated into one new locality instead of separate localities. The commenters stated that either of these variations would reduce the number of new localities created under option 2.

Additionally, the CMA and a California county medical society suggested a variation of option 4 (Statewide Tiers). The commenters stated that fixed cost tiers be established for each State using .05 GAF increments which would lock in the upper and lower GAF values for each cost tier. Under this approach, the fixed cost tiers would not change based on updates to the GPCIs; however, a county could be moved to a lower (or higher) cost tier without the need to define new tiers for the entire state.

(7) Redistribution of Payment

Many commenters acknowledged that a significant redistribution of payments would occur under each alternative locality configuration option and requested that we minimize the payment discrepancy between urban and rural areas to ensure continued access to services. Additionally several commenters stated that any changes to the locality configuration should not be unfair to rural practitioners. One specialty college noted that any new locality configuration must be budget neutral, resulting in a shift of resources from one geographic area to another. The commenter expressed concern that the requirement for budget neutrality may help physicians who practice in certain geographic areas, but will be costly to others. As such, the commenters stated that each alternative PFS locality option could create problems for medical access in areas where payments are reduced. As a method to minimize payment reduction, a few commenters requested that we continue the application of the 1.0 work GPCI floor.

The AMA stated that any proposal to reconfigure PFS payment localities should not necessitate budget-neutral payment redistributions. The commenter expressed the concern raised by other commenters that some localities would receive payment increases under some options while other localities would experience significant payment reductions to offset these increases. The commenters requested that if new locality definitions are proposed, new funding should be provided to increase payments in localities that are found to be underpaid. The commenters also stated that budget neutral redistributions would only exacerbate an already flawed and under-funded Medicare PFS. The AMA suggested that States with a Statewide locality should be given the option of remaining a Statewide locality and that CMS should continue its policy of allowing any State the option of converting to a Statewide locality at the request of the State Medical Association.

The Iowa Medical Society stated that Medicare PFS payment levels in Iowa are among the lowest in the country and that the four alternative locality configurations all appear to further reduce payments to State physicians. As such, they requested that Iowa remain a Statewide locality under any nationwide locality change.

Because of the redistribution effect of any locality reconfiguration, some commenters did not find any of the potential alternative locality configurations preferable to the current payment locality structure. For example, one physician academy stated that all four of the alternative locality scenarios result in disproportionately lower GAFs for non-MSA counties. Therefore, the commenter encouraged us to maintain the current locality structure until we identify an alternative that decreases the number of payment localities and supports practitioners in rural and underserved areas. The commenter also expressed support for a locality reconfiguration that minimizes the number of payment localities; does not exceed the current number of 89 localities and eliminates geographic payment adjustments (except those designed to encourage physicians to practice in underserved areas). Furthermore, the Florida Medical Association urged us to work with Congress to remove the application of budget neutrality when making changes to the PFS payment locality structure. The commenter suggested that we use the current GCPI values as a ''floor'' to ensure that future updates to the localities will not result in payment reductions.

(8) Methodology

The CMA and a California county medical society commended the contractor, Acumen, for the accuracy of its calculations, modeling of the options, and observations. However, they recommended a change in the iterative methodology used to develop option 2 and option 3. The commenters stated that the threshold for removing high cost counties from existing localities (option 2) and removing high cost MSAs from Statewide localities (option 3) should be equal to or greater than 5 percent (not just greater than 5 percent) with no rounding up for GAF differences below 5 percent. Additionally, with regard to option 2, the commenters recommended that counties with identical GAFs to the county being considered for a new locality should not be included in the calculation of the ''Rest of Locality'' GAF (which is used for comparison to the higher cost county).

Additionally, the commenters objected to the methodology used for the ''smoothing'' adjustment. The commenters believe that a new locality created by smoothing should not have a significantly lower GAF than it would if the county was a single locality. For example, the commenters noted that San Diego County (which is currently included in the Rest of California locality) has a county-level GAF of 1.056. However, when the smoothing adjustment is applied to the current locality configuration, the GAF for San Diego is 1.018.

One research institute questioned why high cost counties were separated from existing localities (option 2) and high cost MSAs were separated from Statewide localities (option 3); instead of separating low cost counties and low cost MSAs. The commenter stated that the CMS CBSA methodology is not designed to be sensitive enough to detect significant geographic differences in physician compensation and PE. The commenter questioned whether compensation and PE costs are correlated directly with population density.

Clarification on Methodology Used To Develop Alternative Locality Configurations Discussed in the Interim Report

With regard to the iterative methodology used for option 2 and option 3, the contractor, Acumen, analyzed these alternative locality configurations based on its understanding of the MedPAC ideas. A threshold of greater than 5 percent was used to separate high cost counties from existing localities (option 2) and to separate high cost MSAs from Statewide localities (option 3). Additionally, the contractor compared just one county (or MSA) at a time against the weighted average GAF of all the lower-ranked counties in the Medicare locality. Counties with the same GAF were not treated as a group. In ranking counties by GAF, the contractor used physician work RVUs to break ''ties.'' In other words, when two counties in a Medicare locality had the same GAF, the county with the higher physician work RVU was ranked as if it had the higher GAF. Keeping counties with identical GAFs together would be another possible strategy for developing alternative PFS payment localities. The high cost counties and MSAs were removed in the iterative process to reflect ongoing concerns regarding individual high cost counties (usually in ''rest of state'' areas) where the GAF is significantly higher than the norm for the locality. Removing low cost counties would isolate very low cost areas leading to further reductions in PFS payment levels for physicians and practitioners in these counties.

With regard to the sensitivity of the CBSA methodology and whether compensation and PE cost are correlated directly to population density; the CBSA methodology has three types of areas: MSAs, Metropolitan Divisions within MSAs, and non-MSA areas. None of these definitions involve population density per se, although MSAs must include core areas with populations of 50,000 or greater. Given that the CBSA methodology has more regions than the other alternative locality configurations, it could potentially draw on more detailed levels of data than the other options, and therefore, result in a more precise reflection of geographic cost differences.

(9) Suggested Additional Topics for Review

One commenter stated that the interim locality study report should have addressed how a change in payment locality structure might impact a physician's choice regarding practice location and Medicare beneficiary access to physician services.

The CMA and a California county medical society stated that the interim locality study should have included a discussion of payment accuracy under the current locality structure and under each potential locality configuration. The commenters stated that a discussion of the potential negative impact under a particular option without a discussion of the accuracy of payment for each option is misleading. Additionally, they suggested adding a discussion of potential methods to mitigate payment reductions.

(10) Administrative and Operational Issues

We received few comments on administrative and operational issues related to making changes to the PFS payment locality structure. Some commenters stated that a locality revision would impose a minimal amount of additional administrative burden. However, the commenters did not specify whose administrative burden they were assessing. One commenter stated that implementing the CMS CBSA locality configuration (option 1) would be a significant administrative burden. Additionally, one health care plan explained that many Medicare Advantage Plans are based on Medicare fees in specific localities. As such, any fee schedule locality revision would be a large scale and costly administrative undertaking for managed care plans as well as for ''traditional'' Medicare.

(11) Underlying Data

We also received comments on the data used to develop GPCI values. Although we appreciate these comments, the focus of the interim locality study was not intended to be a review of the underlying data sources used to develop GPCI values. As discussed earlier, the interim locality study was a review of potential approaches for redefining the Medicare PFS payment localities.

Response to Comments

We would like to thank the public for the many thoughtful comments on the interim locality study report entitled, ''Review of Alternative GPCI Payment Locality Structures''. As noted by the commenters and reflected in the report, significant payment redistribution would occur if a nationwide change in the PFS locality configuration were undertaken. All four of the potential alternative payment locality configurations reviewed in the report would increase the number of localities and separate higher cost, typically urban areas from lower cost, typically rural ''Rest of State'' areas. In general, payments to urban areas would increase while rural areas would see a decrease in payment under each of the options studied because they would no longer be grouped with higher cost ''urbanized'' areas. We intend to review the suggestions made by the commenters and consider the impact of each of the potential alternative locality configurations. We will also explore whether alternative underlying data sources are available nationwide. A final report will be posted to the CMS Web site after further review of the studied alternative locality approaches.

We are not proposing changes in the PFS locality structure at this time. As explained in the CY 2009 PFS final rule with comment period, in the event we decide to make a specific proposal for changing the locality configuration, we would provide extensive opportunities for public input (for example, town hall meetings or open door forums, as well as opportunities for public comments afforded by the rulemaking process).

C. Malpractice Relative Value Units (RVUs)

1. Background

Section 1848(c) of the Act requires that each service paid under the PFS be comprised of three components: work, PE, and malpractice. From 1992 to 1999, malpractice RVUs were charge-based, using weighted specialty-specific malpractice expense percentages and 1991 average allowed charges. Malpractice RVUs for new codes after 1991 were extrapolated from similar existing codes or as a percentage of the corresponding work RVU. Section 4505(f) of the BBA required us to implement resource-based malpractice RVUs for services furnished beginning in 2000. Initial implementation of resource-based malpractice RVUs occurred in 2000. The statute also requires that we review, and if necessary adjust, RVUs no less often than every 5 years. The first review and update of resource based malpractice RVUs was addressed in the CY 2005 PFS final rule (69 FR 66263). Minor modifications to the methodology were addressed in the CY 2006 PFS final rule (70 FR 70153). In this current rule, we are proposing to implement the second review and update of malpractice RVUs.

2. Proposed Methodology for the Revision of Resource-Based Malpractice RVUs

The proposed malpractice RVUs were developed by Acumen, LLC (Acumen) under contract to us.

The methodology used in calculating the proposed second review and update of resource-based malpractice RVUs largely parallels the process used in the CY 2005 update. The calculation requires information on malpractice premiums, linked to the physician work conducted by different specialties that furnish Medicare services. Because malpractice costs vary by State and specialty, the malpractice premium information must be weighted geographically and across specialties. Accordingly, the proposed malpractice expense RVUs are based upon three data sources:

- Actual CY 2006 and CY 2007 malpractice premium data.
- CY 2008 Medicare payment data on allowed services and charges.
- CY 2008 Geographic adjustment data for malpractice premiums.

Similar to the previous update of the resource-based malpractice expense RVUs, we are proposing to revise the RVUs using specialty-specific malpractice premium data because they represent the actual malpractice expense to the physician. In addition, malpractice premium data are widely available through State Departments of Insurance. We propose to use actual CY 2006 and CY 2007 malpractice premium data because they are the most current data available (CY 2008 malpractice premium data were not consistently available during the data collection process). Accounting for market shares, three fourths of all included rate filings were implemented in CY 2006 and CY 2007. The remaining rate filings were implemented in CY 2003 through CY 2005 but still effective in CY 2006 and CY 2007. Carriers submit rate filings to their State Departments of Insurance listing the premiums and other features of their coverage. The rate filings include an effective date, which is the date the premiums go into effect. Some States require premium changes to be approved before their effective date; others just require the rate filings to be submitted. We try to capture at least 2 companies and at least 50 percent of the market share, starting with the largest carriers in a State.

The primary determinants of malpractice liability costs continue to be physician specialty, level of surgical involvement, and the physician's malpractice history. We collected malpractice premium data from 49 States and the District of Columbia for all physician specialties represented by major insurance providers. Rate filings were not available through Departments of Insurance in Mississippi or Puerto Rico. Premiums were for $1 million/$3 million, mature, claims-made policies (policies covering claims made, rather than services furnished during the policy term). A $1 million/$3 million liability limit policy means that the most that would be paid on any claim is $1 million and that the most that the policy would pay for several claims over the timeframe of the policy is $3 million. We collected data from commercial and physician-owned insurers and from joint underwriting associations (JUAs). A JUA is a State government-administered risk pooling insurance arrangement in areas where commercial insurers have left the market. Adjustments were made to reflect mandatory surcharges for patient compensation funds (PCFs) (funds to pay for any claim beyond the statutory amount, thereby limiting an individual physician's liability in cases of a large suit) in States where PCF participation is mandatory. We sought to collect premium data representing at least 50 percent of physician malpractice premiums paid in each State as identified by State Departments of Insurance and by the National Association of Insurance Commissioners (NAIC).

Rather than select the top 20 physician specialties as when the malpractice RVU were originally established and updated, we included premium information for all physician and surgeon specialties and risk classifications available in the collected rate filings. Most insurance companies provided crosswalks from insurance services office (ISO) codes to named specialties; we matched these crosswalks to CMS specialty codes. We also preserved information obtained regarding surgery classes, which are categorizations that affect premium rates. For example, many insurance companies grouped general practice physicians into nonsurgical, minor-surgical and major-surgical classes, each with different malpractice premiums. Some companies provided additional surgical subclasses; for example, distinguishing general practice physicians that conducted obstetric procedures, which further impacted malpractice rates. We standardized this information to CMS specialty codes.

We could not identify malpractice premium rates through typical malpractice rate filings for some physician specialties, nonphysician practitioners (NPPs), and other entities (for example, independent diagnostic testing facilities (IDTFs)) paid under the PFS. In the absence of available premium data for these specialties and entities, we took a number of steps.

We collected data from one of the largest association program insurance brokers and administrators in the United States providing malpractice insurance to medical physicists. We incorporated the data into the calculation of the proposed update to the malpractice RVUs for TC services. (*See* section II.C.3 of this proposed rule for a discussion of this issue.)

We also crosswalked 13 specialties for which there was not significant collected data available (those in less than 35 States' malpractice premium rate filings) to similar specialties and risk classes. The unassigned specialties and the specialty to which we are proposing to assign them are shown in Table 4. The remaining four specialties were dropped, meaning they were not included in the weighted averages for calculating the malpractice RVUs.

Note: While we were able to collect data on many more specialties on this survey than under the previous one, these four specialties were also dropped under the previous version of the survey because of a lack of available data. This left 44 specialties, representing 90 percent of Medicare services, for which we used the malpractice premium data to develop risk factors.

TABLE 4—CROSSWALK OF SPECIALTIES TO SIMILAR PHYSICIAN SPECIALTIES

Spec. code	Specialty name	Crosswalk specialty code	Crosswalk specialty
09	Interventional Pain Management	72	Pain Management.
19	Oral Surgery	03	Allergy Immunology*.
35	Chiropractic	03	Allergy Immunology*.
62	Psychologist	03	Allergy Immunology*.
65	Physical Therapist	03	Allergy Immunology*.

TABLE 4—CROSSWALK OF SPECIALTIES TO SIMILAR PHYSICIAN SPECIALTIES—Continued

Spec. code	Specialty name	Crosswalk specialty code	Crosswalk specialty
67	Occupational Therapist	03	Allergy Immunology*.
68	Clinical Psychologist	03	Allergy Immunology*.
79	Addiction Medicine	03	Allergy Immunology*.
85	Maxillofacial Surgery	03	Allergy Immunology*.
86	Neuropsychiatry	26	Psychiatry.
91	Surgical Oncology	02	General Surgery.
94	Interventional Radiology	30	Diagnostic Radiology.
98	Gynecological/Oncology	90	Medical Oncology.
99	Unknown Physician Specialty	01	General Practice.

*Lowest Physician Specialty.

The methodology presented in this proposed rule conceptually follows the specialty-weighted approach used in the CY 2000 and CY 2005 PFS final rules with comment period (63 FR 59383 and 69 FR 66263, respectively) and incorporates the minor modifications discussed in the CY 2006 final rule with comment period (70 FR 70153). We revised the current specialty-weighted approach to accommodate additional data gathered during the malpractice premium data collection. The specialty-weighted approach bases the malpractice RVUs upon a weighted average of the risk factors of all specialties furnishing a given service. This approach ensures that all specialties furnishing a given service are accounted for in the calculation of the final malpractice RVUs. Our proposed methodology is as follows:

(1) *Compute a preliminary national average premium for each specialty.* Insurance rating area malpractice premiums for each specialty were mapped to the county level. The specialty premium for each county is then multiplied by the total county RVUs (as defined by Medicare claims data), which had been divided by the malpractice GPCI applicable to each county to standardize the relative values for geographic variations. If the malpractice RVUs were not normalized for geographic variation, the locality cost differences (as reflected by the GPCIs) would be counted twice. The product of the malpractice premiums and standardized RVUs is then summed across counties for each specialty. This calculation is then divided by the total RVUs for all counties, for each specialty, to yield a national average premium for each specialty.

(2) *Determine which risk class(es) to use within each specialty.* Many specialties had premium rates that differed for major surgery, minor surgery, and no surgery. These surgery classes are designed to reflect differences in risk of professional liability and the cost of malpractice claims if they occur. The same concept applies to procedures; some procedures carry greater liability risks. Accordingly, we identified major, minor, nonsurgical, and obstetric procedures among all Medicare procedures by established indicators (Global Surgery Flags). Table 5 shows the surgery class definitions used in the proposed methodology.

TABLE 5—SURGERY CLASSES BY PROCEDURE CODE

Surgery class	CPT code range	Global surgery flag
Major Surgery (Maj)	10000–69999	90 Day.
Minor Surgery (Min)	10000–69999	All Other.
Obstetrics (OB)	59000–59899	N/A.
No Surgery (NS)	All other CPT Codes	N/A.

To account for the presence of surgery classes in the malpractice premium data and the task of mapping these premiums to procedures, we sought to calculate distinct risk factors for major, minor, and nonsurgical procedures, as well as a comparable approach for obstetric premiums and procedures. However, the availability of data by surgery class varied across specialties. In light of the complexity of the surgery class data, we evaluated both the frequency with which rate class data were reported and a preliminary set of normed national average premiums, calculated for all classes reported in the data. Because no single approach accurately addressed the risk weights and value differences of various specialty/procedure combinations, we developed five strategies for handling the surgical classes and defining specialties. These strategies are summarized in Table 6.

(a) *Substantial Data for Each Class:* For 13 out of 44 specialties, we determined that there was sufficient data for each surgical class, as well as sufficient differences in rates between classes, to use the surgical class data as the basis for risk factors by surgical class.

(b) *Major Surgery Dominates:* These 8 surgical specialties typically had rate filings that specified major surgery as the predominate rate reported. Filings that distinguished minor surgery or nonsurgical were relatively rare. For most of these surgical specialties, we did not have ''unspecified'' rate filings. When we had ''unspecified'' rate filings, the unspecified category was sometimes above and sometimes below the major surgery rate. For these cases, we assigned the premium for major surgery to all procedures conducted by this specialty. (In practice, the major surgery procedures dominate the services actually furnished.)

(c) *Little or No Data for Major Surgery:* For five other specialties, specific premiums for major surgery were uncommon, but most States had rate filings that represented minor surgery or nonsurgical coverage. These five specialties had unspecified rates that were less common than the minor surgery-nonsurgery distinction and the nonsurgery rates. Therefore, for these five specialties we assigned the minor surgery rate filings for both major surgery and minor surgery procedures, and the nonsurgery filings for nonsurgical procedures.

(d) *Unspecified Dominates:* Many malpractice rate filings did not specify surgery classes for some specialties; we refer to these instances as unspecified malpractice rates. In only two cases, we choose the unspecified premium as the premium information to use for the specialty. For both of these specialties, fewer than 20 States had rate filings that distinguished by surgical classes, while more than 40 had general rate filings for the specialty.

(e) *Blend All Available:* For the last 16 specialties, there was wide variation across the State filings in terms of whether or not surgical classes were reported and which categories were reported. Because there was no clear strategy for these remaining specialties, we blended the rate information we collected into one general premium rate and applied that rate for all three premiums (major, minor and nonsurgical). For these specialties, we developed a weighted average ''blended'' premium at the national level, according to the percentage of physician work RVUs correlated with the surgery classes within each specialty.

TABLE 6—SUMMARY OF APPROACHES TO DEFINING PREMIUMS BY SURGICAL CLASS

Situation	Specialty codes
1. Substantial Data for Each Class (13)	01 (non-OB), 04, 06, 07. 08 (non-OB), 10, 13, 18. 16 (non-OB), 38, 39, 46, 93.
2. Major Surgery Dominates (8)	02, 14, 20, 24, 28, 33, 77, 78.
3. Little or No Data for Major Surgery (5)	11, 22, 37, 44, 82.
4. Unspecified Dominates (2)	05, 72.
5. Blend All Available (16)	03, 25, 26, 29, 30, 34, 36, 40, 48, 66, 71, 81, 83, 84, 90, 92.

For rarely-billed Medicare procedures, we did not apply the 5 percent threshold for inclusion of services or specialties as utilized in previous MP RVU updates. Rather, we are proposing to use the risk factor of the dominant specialty by services for each procedure for which the number of allowed services is less than 100. This approach reflects the risk factors of the specialty that most frequently furnishes these low volume procedures.

(3) *Calculate a risk factor for each specialty.* Differences among specialties in malpractice premiums are a direct reflection of the malpractice risk associated with the services furnished by a given specialty. The relative differences in national average premiums between various specialties can be expressed as a specialty risk factor. These risk factors are an index calculated by dividing the national average premium for each specialty by the national average premium for the specialty with the lowest average premium, allergy/immunology. Table 7 shows the risk factors by specialty and surgery class.

TABLE 7—RISK FACTORS BY SPECIALTY AND SURGERY CLASS

Medicare code	Medicare name	Non-surgical RF	Minor-surgical RF	Major-surgical RF
1	General Practice	1.50	2.26	3.56
2	General Surgery	5.87	5.87	5.87
3	Allergy Immunology	1.00	1.00	1.00
4	Otolaryngology	1.44	2.37	3.55
5	Anesthesiology	2.22	2.22	2.22
6	Cardiology	1.87	2.65	6.09
7	Dermatology	1.14	2.06	3.96
8	Family Practice	1.57	2.23	3.79
10	Gastroenterology	2.03	2.48	4.09
11	Internal Medicine	1.72	2.52	2.52
13	Neurology	2.20	2.90	10.28
14	Neurosurgery	9.94	9.94	9.94
16	Obstetrics Gynecology	1.67	2.37	4.64
18	Ophthalmology	1.07	1.68	1.90
19	Oral Surgery	1.00	1.00	1.00
20	Orthopedic Surgery	5.46	5.46	5.46
22	Pathology	1.74	2.26	2.26
24	Plastic and Reconstructive Surgery	5.51	5.51	5.51
25	Physical Medicine and Rehabilitation	1.14	1.14	1.14
26	Psychiatry	1.22	1.22	1.22
28	Colorectal Surgery	3.99	3.99	3.99
29	Pulmonary Disease	2.08	2.08	2.08
30	Diagnostic Radiology	2.62	2.62	2.62
33	Thoracic Surgery	6.51	6.51	6.51
34	Urology	2.64	2.64	2.64
35	Chiropractic	1.00	1.00	1.00
36	Nuclear Medicine	1.55	1.55	1.55
37	Pediatric Medicine	1.49	2.41	2.41
38	Geriatric Medicine	1.43	2.23	4.22
39	Nephrology	1.61	2.27	4.17
40	Hand Surgery	3.49	3.49	3.49
44	Infectious Disease	2.09	2.52	2.52
46	Endocrinology	1.51	2.23	4.46

TABLE 7—RISK FACTORS BY SPECIALTY AND SURGERY CLASS—Continued

Medicare code	Medicare name	Non-surgical RF	Minor-surgical RF	Major-surgical RF
48	Podiatry	1.98	1.98	1.98
62	Psychologist	1.00	1.00	1.00
65	Physical Therapist	1.00	1.00	1.00
66	Rheumatology	1.56	1.56	1.56
67	Occupational Therapist	1.00	1.00	1.00
68	Clinical Psychologist	1.00	1.00	1.00
71	Registered Dietitian/Nutrition Professional	1.54	1.54	1.54
72	Pain Management	2.21	2.21	2.21
77	Vascular Surgery	6.50	6.50	6.50
78	Cardiac Surgery	6.89	6.89	6.89
79	Addiction Medicine	1.00	1.00	1.00
81	Critical Care (Intensivists)	2.15	2.15	2.15
82	Hematology	1.59	2.03	2.03
83	Hematology/Oncology	1.72	1.72	1.72
84	Preventive Medicine	1.16	1.16	1.16
85	Maxillofacial Surgery	1.00	1.00	1.00
86	Neuropsychiatry	1.22	1.22	1.22
90	Medical Oncology	1.76	1.76	1.76
91	Surgical Oncology	5.87	5.87	5.87
92	Radiation Oncology	2.30	2.30	2.30
93	Emergency Medicine	2.29	3.77	4.87
94	Interventional Radiology	2.62	2.62	2.62
98	Gynecological/Oncology	1.76	1.76	1.76
99	Unknown Physician Specialty	1.50	2.26	3.56

One complication in the calculation of specialty risk factors is technical component (TC) data. Many procedures are comprised of professional components (PC) and TCs. These components are referred to as global procedures when billed together. The TC represents the cost of equipment, supplies, and technician/staff salaries involved in furnishing a procedure, such as the taking of an x-ray by a technician. The PC represents the portion of a service that is furnished by a physician such as the interpretation of an x-ray by the physician. The distinction is important because PCs and TCs have different associated risk factors and face different malpractice insurance costs. The previous update of the malpractice RVUs did not update the TCs due to the lack of available malpractice premium data for entities providing TC services. In the past, we were unable to obtain data concerning malpractice costs associated with the TC, so we based the malpractice RVUs for TC services and the TC portion of global services on historical allowed charges.

We have had ongoing discussions with the AMA RUC and various specialty societies about this issue. In the CY 2008 PFS proposed rule (72 FR 38143), we noted that the Professional Liability Insurance (PLI) workgroup, a subset of the AMA RUC brought to our attention the fact that there are approximately 600 services that have TC malpractice RVUs that are greater than the PC malpractice RVUs. The PLI workgroup requested that we make changes to these malpractice RVUs and suggested that it is illogical for the malpractice RVUs for the TC of a service to be higher than the malpractice RVUs for the PC.

We responded that we would like to develop a resource-based methodology for the technical portion of these malpractice RVUs; but that we did not have data to support such a change. We asked for information about whether, and if so, how technicians employed by facilities purchase PLI or how their professional liability is covered. We also asked for comments on what types of PLI are carried by entities that furnish these technical services.

In the CY 2009 PFS proposed rule (73 FR 38515), we stated that the issue of assigning malpractice RVUs for the TC of certain services continues to be a source of concern for several physician associations and for CMS. We noted that we did not receive a response to our CY 2008 request for additional data on this issue and that this issue is one of importance to CMS. We also stated that the lack of available PLI data affects our ability to make a resource-based evaluation of the TC malpractice RVUs for these codes. We indicated that as part of our work to update the malpractice RVUs in CY 2010, we would instruct our contractor to research available data sources for the malpractice costs associated with the TC portion of these codes and that we would also ask the contractor to look at what is included in general liability insurance versus PLI for physicians and other professional staff. We also stated that if data sources were available, we would instruct the contractor to gather the data so we will be ready to implement revised malpractice RVUs for the TC of these codes in conjunction with the update of malpractice RVUs for the PCs in CY 2010.

In the CY 2009 PFS final rule (73 FR 69741), we again responded to comments on this issue. We noted that one commenter provided us with the name of a company that provides liability insurance to imaging facilities. We stated that we planned to share the information with our contractor and that if premium data could be identified; it would be incorporated into the malpractice RVU update. Our contractor, Acumen LLC, contacted the company suggested by the commenter and obtained medical physicist malpractice premium data from one of the largest association program insurance brokers and administrators in the United States providing this type of malpractice insurance. The premium data indicate that medical physicists have very low malpractice premiums relative to physicians.

Medical physicists are involved in complex services such as Intensity-Modulated Radiation Therapy (IMRT). IMRT is an advanced mode of radiotherapy that utilizes computer-controlled x-ray accelerators to deliver radiation doses to a malignant tumor. Based on the complexity of these services, we believe that medical

physicists would pay one of the highest malpractice premium rates of the entities furnishing TC services and that using their data as a proxy (in the absence of actual premium data) to develop malpractice RVUs for TC services would be more realistic than our current approach for these entities. Moreover, we believe it is unlikely that actual malpractice premium rates for these entities would exceed those for medical physicists. Therefore, based on this new data collection, we are proposing to use the medical physicists' premium data as a proxy for the malpractice premiums paid by entities providing TC services. We believe that the use of this data will better reflect the level of malpractice premiums paid by entities providing TC services than the current charge-based malpractice RVUs or crosswalks to the malpractice premium data of physician specialties.

As we have done in the past, we continue to encourage public commenters to submit or identify alternative data that we might use for the purpose of establishing malpractice RVUs.

(4) *Calculate malpractice RVUs for each code.* Resource-based malpractice RVUs were calculated for each procedure. The first step was to identify the percentage of services furnished by each specialty for each respective procedure code. This percentage was then multiplied by each respective specialty's risk factor as calculated in Step 3. The products for all specialties for the procedure were then added together, yielding a specialty-weighted malpractice RVU reflecting the weighted malpractice costs across all specialties for that procedure. This sum was then multiplied by the procedure's work RVUs to account for differences in risk-of-service.

Certain codes have no physician work RVUs. The overwhelming majority of these codes are the TCs of diagnostic tests, such as x-rays and cardiac catheterization, which have a distinctly separate TC (the taking of an x-ray by a technician) and PC (the interpretation of the x-ray by a physician). Examples of other codes with no work RVUs are audiology tests and injections. These services are usually furnished by NPPs, in this example, audiologists and nurses, respectively. In many cases, the NPP or entity furnishing the TC is distinct and separate from the physician ordering and interpreting the test. We believe it is appropriate for the malpractice RVUs assigned to TCs to be based on the malpractice costs of the NPP or entity, not the professional liability of the physician.

Our proposed methodology, however, would result in zero malpractice RVUs for codes with no physician work, since we propose the use of physician work RVUs to adjust for risk-of-service. We believe that zero malpractice RVUs for reasons other than rounding would be inappropriate because NPPs and entities such as IDTFs also have malpractice liability.

Note that the earlier discussion above in ''(3) Calculate a risk factor for each specialty'' addressed the proposed use of the medical physicist premium data to develop a TC risk factor. This TC risk factor is used in (3), as noted above, along with the global risk factor to calculate a PC risk factor. Once the global and PC risk factors are calculated, they are used here in step (4) to calculate the global and PC malpractice RVUs. Once we have calculated the global and PC malpractice RVUs, we propose to address the lack of work RVUs for TC services by setting the TC malpractice RVUs equal to the difference between the global malpractice RVUs and PC malpractice RVUs.

(5) *Rescale for budget neutrality.* The statute requires that changes to fee schedule RVUs be budget neutral. The current resource-based malpractice RVUs and the proposed resource-based malpractice RVUs were constructed using entirely different malpractice premium data. Thus, the last step is to adjust for budget neutrality by rescaling the proposed malpractice RVUs so that the total proposed resource-based malpractice RVUs equal the total current resource-based malpractice RVUs.

We are requesting comments on our proposed methodology for updating the malpractice RVUs. We are especially interested in comments on our proposed process for revising the malpractice RVUs of the TC of codes with no physician work. Additionally, we intend to post the Acumen report, ''Interim Report on Malpractice RVUs for the CY 2010 Medicare Physician Fee Schedule Proposed Rule'' on the CMS Web site in conjunction with publication of this proposed.

D. Medicare Telehealth Services

1. Requests for Adding Services to the List of Medicare Telehealth Services

Section 1834(m)(4)(F) of the Act defines telehealth services as professional consultations, office visits, and office psychiatry services, and any additional service specified by the Secretary. In addition, the statute requires us to establish a process for adding services to or deleting services from the list of telehealth services on an annual basis.

In the December 31, 2002 **Federal Register** (67 FR 79988), we established a process for adding services to or deleting services from the list of Medicare telehealth services. This process provides the public an ongoing opportunity to submit requests for adding services. We assign any request to make additions to the list of Medicare telehealth services to one of the following categories:

- *Category #1:* Services that are similar to professional consultations, office visits, and office psychiatry services. In reviewing these requests, we look for similarities between the requested and existing telehealth services for the roles of, and interactions among, the beneficiary, the physician (or other practitioner) at the distant site and, if necessary, the telepresenter. We also look for similarities in the telecommunications system used to deliver the proposed service, for example, the use of interactive audio and video equipment.
- *Category #2:* Services that are not similar to the current list of telehealth services. Our review of these requests includes an assessment of whether the use of a telecommunications system to deliver the service produces similar diagnostic findings or therapeutic interventions as compared with the face-to-face ''hands on'' delivery of the same service. Requesters should submit evidence showing that the use of a telecommunications system does not affect the diagnosis or treatment plan as compared to a face-to-face delivery of the requested service.

Since establishing the process, we have added the following to the list of Medicare telehealth services: Psychiatric diagnostic interview examination; ESRD services with two to three visits per month and four or more visits per month (although we require at least one visit a month to be furnished in-person ''hands on,'' by a physician, clinical nurse specialist (CNS), nurse practitioner (NP), or physician assistant (PA) to examine the vascular access site); individual medical nutrition therapy; neurobehavioral status exam; and follow-up inpatient telehealth consultations.

Requests to add services to the list of Medicare telehealth services must be submitted and received no later than December 31 of each calendar year to be considered for the next rulemaking cycle. For example, requests submitted before the end of CY 2008 are considered for the CY 2010 proposed rule. Each request for adding a service to the list of Medicare telehealth

services must include any supporting documentation you wish us to consider as we review the request. Because we use the annual PFS rulemaking process as a vehicle for making changes to the list of Medicare telehealth services, requesters should be advised that any information submitted is subject to disclosure for this purpose. For more information on submitting a request for an addition to the list of Medicare telehealth services, including where to mail these requests, visit our Web site at *http://www.cms.hhs.gov/telehealth/*.

2. Submitted Requests for Addition to the List of Telehealth Services

We received requests in CY 2008 to add the following services as Medicare telehealth services effective for CY 2010: (1) Health and behavior assessment and intervention (HBAI) procedures; and (2) nursing facility services. In addition, we received a number of requests to add services that we considered previously and did not approve as Medicare telehealth services in previous PFS rules. These requested services include critical care services; initial and subsequent hospital care; group medical nutrition therapy; diabetes self-management training; speech and language pathology services; and physical and occupational therapy services. The following is a discussion of these requests.

a. Health and Behavior Assessment and Intervention (HBAI)

The American Psychological Association (APA) submitted a request to add HBAI services (as described by HCPCS codes 96150 through 96154) to the list of approved telehealth services. The APA asks us to evaluate and approve HBAI services as Category #1 service because they are comparable to the psychotherapy services currently approved for telehealth.

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To determine whether to assign a request to Category #1, we look for similarities between the service that is being considered for addition and the existing telehealth services in the roles of, and interactions among, the beneficiary, the physician (or other practitioner) at the distant site and, if necessary, the telepresenter.

Clinical psychologists furnish HBAI services to beneficiaries to help them manage or improve their behavior in response to physical problems. Elements of HBAI services typically include interviewing, observing, and counseling beneficiaries to help them modify their behavior. These elements are also common to the office psychiatry services currently approved for telehealth. We believe the interaction between a practitioner and a beneficiary receiving individual HBAI services (as described by HCPCS codes 96150 through 96152) is similar to the assessment and counseling elements of the individual office psychiatry services currently approved for telehealth. Therefore, we are proposing to revise § 410.78 and § 414.65 to include individual HBAI services as Medicare telehealth services.

With regard to group HBAI (as described by HCPCS code 96153) or family-with-patient HBAI (as described by HCPCS code 96154), we note that no group services are currently approved as Medicare telehealth services. Group counseling services have a different interactive dynamic between the physician or practitioner and his or her patients as compared to individual services. No other group counseling or other group services are approved as telehealth services. Since the interactive dynamic for group HBAI services is not similar to that for individual HBAI services or any other approved telehealth services, we do not believe that group HBAI or family-with-patient HBAI services are properly considered as Category #1 requests. To be considered as a Category #1 request, a service must be similar to the current list of Medicare telehealth services. (See 70 FR 45787 and 70157, and 73 FR 38516 and 69743).

Since the interactive dynamic between practitioner and patient for group HBAI and family-with-patient HBAI is not similar to that for office psychiatry services or any other service currently approved for telehealth, we believe that group HBAI and family-with-patient HBAI must be evaluated as Category #2 services. Because we consider group HBAI and family-with-patient HBAI to be Category #2 services, we need to evaluate whether these are services for which telehealth can be an adequate substitute for a face-to-face encounter. The requester did not submit evidence suggesting that the use of a telecommunications system to deliver these services would produce similar diagnostic findings or therapeutic interventions as compared to the face-to-face delivery of these services. As such, we do not propose to add group HBAI (as described by HCPCS code 96153) or family-with-patient HBAI (as described by HCPCS code 96154) to the list of approved telehealth services.

b. Nursing Facility Services

In 2005, we received a request to add the following nursing facility services to the list of approved telehealth services: Initial nursing facility care (as described by HCPCS codes 99304 through 99306); subsequent nursing facility care (HCPCS codes 99307 through 99310); nursing facility discharge services (HCPCS codes 99315 and 99316); and other nursing facility services (HCPCS code 99318). In the CY 2007 PFS final rule with comment period, we did not add these nursing facility care services to the list of approved telehealth services because these procedure codes did not describe services that were appropriate to add to the list of available telehealth originating sites in CY 2007. At that time, skilled nursing facilities (SNFs) were not defined in the statute as originating sites (71 FR 69657).

However, section 149 of the MIPPA added SNFs as telehealth originating sites effective for services furnished on or after January 1, 2009. In light of this provision, the American Telemedicine Association (ATA) urged us to add nursing facility care codes to the list of telehealth services for CY 2009, as requested in 2005.

In the CY 2009 PFS final rule with comment period, we noted that section 149 of the MIPPA did not add any services to the list of Medicare telehealth services. In the CY 2009 PFS final rule with comment period, we also responded to the ATA's comment suggesting that we add nursing facility care codes to the list of telehealth services for CY 2009, as requested in 2005. In our response, we noted that when we received the 2005 request to consider the addition of nursing facility care services for telehealth for CY 2007, we did not include a full review of these codes in either the CY 2007 PFS proposed rule or final rule with comment period since we believed it was not relevant to add the nursing facility services codes when the SNFs in which these services would be furnished were not eligible originating sites. In the CY 2009 PFS final rule with comment period, we responded that we believe it would be more appropriate to consider the addition of nursing facility care services for telehealth through our existing process, including full notice and comment procedures. We committed to revisiting the 2005 request to add the nursing facility codes in the CY 2010 PFS proposed rule, and we noted that we would accept additional information in support of the 2005 request if we received the information prior to December 31, 2008 (73 FR 69747).

Subsequent to publication of the CY 2009 PFS final rule with comment period, the ATA submitted an amended request to add subsequent nursing facility care; nursing facility discharge

services; and other nursing facility services to the list of approved telehealth services. The Center for Telehealth and e-Health Law submitted a request to add the same nursing facility services and indicated its support of ATA's request. We also received a request from the Marshfield Clinic to add the same services requested by the ATA, plus the initial nursing facility care services. The requesters drew analogies to the evaluation and management (E/M) services currently approved for telehealth, and they provided evidence in support of their belief that the use of telehealth could be a reasonable surrogate for the face-to-face delivery of this type of care.

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The procedure codes included in these requests are used to report E/M services furnished onsite to patients in nursing facilities. In the context of these codes, ''nursing facility'' describes SNFs, NFs, intermediate care facilities, and psychiatric residential treatment centers.

Medicare telehealth services can only be furnished to beneficiaries located at an originating site authorized by law. A SNF (as defined in section 1819(a) of the Act) is the only type of nursing facility that can also be considered an originating site for telehealth services. Therefore, our review of these services focuses on the potential impact of adding these services when furnished via telehealth to a Medicare beneficiary located in a SNF.

Federally-Mandated Visits in Skilled Nursing Facilities

In describing our assessment, we first describe the service requirements of a Medicare SNF stay. In response to concerns about inadequate care provided to residents of nursing homes, the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) (Pub. L. 100–203) included extensive revisions to the requirements for Medicare and Medicaid certified nursing homes. These provisions were designed to significantly improve the quality of life and the quality of care provided to residents of nursing homes, and were a high priority for the Department of Health and Human Services.

Specific requirements for assuring the quality of care that SNFs must meet to participate in Medicare are specified in section 1819 of the Act. In addition, section 1819(d)(4)(B) of the Act provides that ''[a] skilled nursing facility must meet such other requirements relating to the health, safety, and well-being of residents or relating to the physical facilities thereof as the Secretary may find necessary.'' The provisions of 42 CFR Part 483 codify the requirements set forth in the statute that long term care facilities are obligated to meet in order to participate in the Medicare and/or Medicaid program.

Section 1819(b)(6)(A) of the Act requires that the medical care of every SNF resident must be provided under the supervision of a physician. The requirements contained in § 483.40 include a prescribed visit schedule and specify that the physician must perform the initial visit personally. Section 483.40(c) requires that the resident of a SNF must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. As we indicated in the preamble to the February 2, 1989 final rule (54 FR 5341), and again in response to comments in the September 26, 1991 final rule (56 FR 48826), the wording of the regulation states that the resident ''must be seen'' by the physician and requires an actual, face-to-face contact. Except for certain stated exceptions, all required physician visits must be made personally by the physician. Section 483.40(e)(2) requires that when personal performance of a particular task by a physician is specified in the regulations, performance of that task cannot be delegated to anyone else. Section 483.40(c)(4) requires that the physician must perform the initial visit personally, and § 483.40(c)(5), allows the physician the option of alternating with a qualified NPP (that is, physician assistant, nurse practitioner, or clinical nurse specialist) in making the subsequent required visits. These regulations ensure that at least a minimal degree of personal contact between physician or qualified NPP and resident is maintained, both at the point of admission to the facility and periodically during the course of the resident's stay (54 FR 5342).

In the CY 2009 PFS final rule with comment period (73 FR 69747), we noted that in considering nursing facility care for telehealth, we would need to carefully evaluate the use of telehealth for the personal visits that are currently required under § 483.40. The OBRA '87 and other long-term care legislation enacted since then require a SNF to care for its residents ''in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident'' as specified in section 1819(b)(1)(A) of the Act. We believe that a minimum number of periodic, comprehensive, hands-on examinations of a resident by a physician or a qualified NPP are necessary to ensure that the resident receives quality care. We believe that the complexity of care required by many residents of SNFs warrants at least a minimal degree of direct personal contact between physicians or qualified NPPs and SNF residents. Therefore, we believe that these Federally-mandated visits should be conducted in-person, and not as telehealth services, in order to provide direct personal contact between the resident and the physician or qualified NPP.

In the MMA, the Congress recognized the importance of furnishing the Federally-mandated visits in person, rather than via telehealth. Section 418 of the MMA required the Secretary to submit a Report to Congress evaluating the use of telehealth in SNFs. If the Secretary determined that it was advisable to permit a SNF to be an originating site for telehealth services, the MMA provided the Secretary with the authority to expand telehealth originating sites to include SNFs. SNFs were permitted to be added as originating sites only if the Secretary could establish a mechanism to ensure that telehealth does not serve as a substitute for in-person visits furnished by a physician, or for in-person visits furnished by a physician assistant, nurse practitioner, or clinical nurse specialist.

On November 9, 2007, the Secretary provided to Congress the report specified under section 418 of the MMA, entitled, ''Permitting Skilled Nursing Facilities to be Originating Telehealth Sites.'' Overall, the Report noted that evidence concerning the net impact of allowing SNFs to be originating telehealth sites was not conclusive and further analysis was needed. With respect to Federally-mandated visits in SNFs, the Report stated that the Secretary could use its authority to add services to and delete services from the list of Medicare telehealth services as a mechanism to ensure that Federally-mandated visits are not furnished as a Medicare telehealth service by not adding these visits to the lists of Medicare telehealth services.

In consideration of the history of the OBRA '87, 42 CFR part 483, and Congressional concern expressed in section 418 of the MMA, we do not propose to add any procedure codes that are used exclusively to describe E/M services that fulfill Federal requirements for personal visits under § 483.40. We are proposing to revise § 410.78 to restrict physicians and practitioners from using telehealth to furnish the physician visits required under § 483.40(c).

In the following sections, we will separately review the use of telehealth for each of the subcategories of nursing facility services included in these requests. In these discussions, we will also indicate which of these subcategories are used to describe E/M services that fulfill Federal requirements for personal visits under § 483.40.

Initial Nursing Facility Care

The initial nursing facility care procedure codes (as described by HCPCS codes 99304 through 99306) are used to report the initial E/M visit in a SNF or NF that fulfills Federally-mandated requirements under § 483.40(c). For survey and certification requirements, this initial visit must occur no later than 30 days after admission. In a SNF, a physician must furnish the initial visit.

One of the requesters noted that once the patient is transferred to the SNF, it might be days until a physician can see a resident in-person. The requester believes a higher quality of care would be provided if the initial nursing facility service can be done in an expeditious manner—via telehealth—rather than delayed until the physician is on site.

As noted above, we are not proposing to add any procedure codes that are used exclusively to describe E/M services that fulfill Federal requirements for personal visits under § 483.40. We believe that these Federally-mandated visits should be conducted in-person because this will ensure at least a minimal degree of direct personal contact between physicians or qualified NPPs and residents. Further, we believe it is particularly important that the Federally-mandated initial visit should be conducted in-person because this will ensure that the physician can comprehensively assess the resident's condition upon admission to the SNF through a thorough hands-on examination. We believe that even if the initial visit is delayed for a few days, it is necessary for the resident of a SNF to have a face-to-face visit with the physician who is developing a plan of care. Under section 1819(b)(2) of the Act, a SNF must provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. We believe that furnishing the initial visit in a face-to-face encounter, and not via telehealth, is necessary to assure quality care. As such, we are not proposing to add the initial nursing facility care services (as described by HCPCS codes 99304 through 99306) to the list of approved telehealth services.

Subsequent Nursing Facility Care

The subsequent nursing facility care procedure codes (as described by HCPCS codes 99307 through 99310) are used to report either a Federally-mandated periodic visit under § 483.40(c), or any E/M visit, prior to and after the initial physician visit, that is reasonable and medically necessary to meet the medical needs of the individual resident.

The long-term care regulations at § 483.40 require periodic physician visits for residents of SNFs (and NFs) at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. After the initial visit, Federally-mandated periodic visits in SNFs may, at the option of the physician, alternate between personal visits by the physician and visits by a qualified NPP (who is under the supervision of a physician, and meets the other requirements specified at § 483.40(e)). As noted above, we are not proposing to allow the use of telehealth to furnish these Federally-mandated personal visits. We believe that these Federally-mandated periodic visits should be conducted in-person because this will ensure at least a minimal degree of direct personal contact between physicians or qualified NPPs and residents. Under section 1819(b)(2) of the Act, a SNF must provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. We believe that furnishing the periodic personal visits in face-to-face encounters, and not via telehealth, is necessary to assure quality care.

We considered the possibility of approving subsequent nursing facility care for telehealth with specific limitations, for example, approving subsequent nursing facility care for telehealth only when the codes are used for medically necessary E/M visits that are in addition to Federally mandated periodic personal visits. In past years, we did not add hospital E/M visits to the list of Medicare approved telehealth services because of our concern regarding the use of telehealth for the ongoing E/M of a high-acuity hospital inpatient. (*See* 69 FR 47511, 69 FR 66276, 72 FR 38144, 72 FR 66250, 73 FR 38517, and 73 FR 69745.) Many residents of SNFs require medically complex care, and we have similar concerns about allowing physicians or NPPs to furnish E/M visits via telehealth to residents of SNFs.

Because the complexity of care required by many residents of SNFs may be significantly greater than the complexity of care generally associated with patients receiving the office visits approved for telehealth, we do not consider E/M visits furnished to residents of SNFs similar to the office visits on the current list of Medicare telehealth services. Therefore, we believe the use of subsequent nursing facility care for medically necessary E/M visits that are in addition to Federally mandated periodic personal visits must be evaluated as a Category #2 service.

Because we consider subsequent nursing facility care to be a Category #2 request, we evaluate whether these are services for which telehealth can be an adequate substitute for a face-to-face encounter. The requesters submitted supporting documentation intended to suggest that the use of telehealth could be a reasonable surrogate for the face-to-face delivery of this type of care.

One study assessed the impact of videoconferencing (as opposed to communication by telephone without video) on nighttime, on-call medical decision-making in the nursing home. The comparison of videoconferencing with telephonic communication of information by nurses does not provide a comparative analysis demonstrating that E/M visits furnished via telehealth to residents of SNFs is equivalent to the face-to-face delivery of such services. As such, this study was not relevant to this review.

Another study assessed the value of a monitoring system in reducing falls and injuries in non-acute late-evening and nighttime situations in a nursing home setting. The monitoring system described in this study was comprised of sensors to alert caregivers via a silent pager when a high-risk resident exits his or her bed, bedroom, or bathroom. This allows caregivers to aid the resident and potentially reduce falls. The technologies utilized in this study do not correspond with our definitions of telehealth as specified in § 410.78. In addition, this type of resident monitoring is performed typically by nursing staff and is not an E/M visit. As such, this study was not relevant to this review.

A third study presented the savings achieved through avoiding transport to emergency departments and physicians' offices by furnishing visits via telehealth to residents in nursing facilities. The study did not provide any comparative analysis of the services furnished via telehealth with those furnished in person.

A fourth study evaluated the impact of telemedicine as a decision aid for residents of long-term care SNFs with chronic wounds. The patients selected for this study were alert and

intellectually interactive. The study concluded that furnishing a telehealth consultation prior to a face-to-face consultation increased the level of patient comfort with care-related decisions made during the face-to-face consultation. The control group did not receive an equivalent intermediate consultation face-to-face that could be compared to the services furnished to the test group. We acknowledge the study's findings that the intermediate telehealth consultation was a useful decision aid, but we do not consider this a comparative analysis between delivery of the same type of care via telehealth versus face-to-face.

We received a pilot study evaluating the usefulness of E/M services furnished via telehealth for making routine medical decisions in the nursing home. The nursing home residents were evaluated over videoconferencing and then evaluated immediately afterward by the same clinician in person. On a scale of 1 to 5 (1 being the least ill), the clinicians assessed the illness level of these residents at 3 or below, with the illness level for over 65 percent of the encounters assessed at ''1.'' Videoconferencing without a face-to-face examination was sufficient for making medical decisions in most cases studied in this pilot, although face-to-face examinations were preferred. Clinicians generated orders in 30 percent of these paired encounters, with a predominance of orders generated after, rather than before, the face-to-face examination. The study also noted that even when nursing home residents were alert, they had limited participation in the telemedicine interactions and were not as involved in making informed medical decisions with their clinicians, compared to face-to-face encounters. The study suggests that remote examination by video might serve as a substitute for some routine visits, if interspersed with face-to-face examinations. The study concluded that videoconferencing is feasible for making routine medical decisions in the nursing home.

We appreciate the comparative analysis provided by this study. However, we note that this study focused on the usefulness of telehealth for routine decision-making in the nursing home, and the reported illness levels of the residents in these sample encounters was relatively low to moderate. We do not consider these findings persuasive that telehealth can, more generally, be an adequate substitute for the face-to-face delivery of E/M visits to residents of SNFs who might require more medically complex care.

We considered the possibility of approving the use of telehealth to furnish E/M visits to residents of SNFs who do not require medically complex care or approving subsequent nursing facility care for telehealth only for medically necessary E/M visits with straightforward or low complexity medical decision-making (as described by HCPCS codes 99307 and 99308). Although this last pilot study concluded that videoconferencing is feasible for making routine medical decisions in the nursing home, we are concerned with the study's finding that residents with low to moderate levels of reported illness had limited participation in the telemedicine interactions and less involvement in making informed medical decisions with their clinicians, compared to face-to-face encounters. Under section 1819(c)(1)(A) of the Act, a SNF must protect and promote the rights of each resident, including the right to be fully informed in advance of any changes in care or treatment that may affect the resident's well-being, and (except with respect to a resident adjudged incompetent) to participate in planning care and treatment or changes in care or treatment. Under § 483.10(b)(3), a resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to his or her medical condition. If the use of telehealth does not elicit from residents with low to moderate reported illness adequate participation in making informed medical decisions with their clinicians when compared to face-to-face encounters, we believe that telehealth is not an adequate substitute for the face-to-face delivery of E/M visits to any residents of SNFs.

After reviewing these studies, we do not have sufficient comparative analysis or other compelling evidence to demonstrate that furnishing E/M visits via telehealth to residents of SNFs is an adequate substitute for the face-to-face encounter between the practitioner and the resident, especially in cases where the resident requires medically complex care. Therefore, we are not proposing to add subsequent nursing facility care services (as described by HCPCS codes 99307 through 99310) to the list of approved telehealth services.

Nursing Facility Discharge Day Management

The nursing facility discharge day management codes (as described by HCPCS codes 99315 and 99316) are used to report an E/M visit that prepares a resident for discharge from a nursing facility. We note that there is no Medicare Part B requirement to furnish and bill an E/M visit in preparation for a resident's discharge from a SNF. However, if a physician or qualified NPP bills a Nursing Facility Discharge Services code, we believe that a face-to-face encounter will better insure that the resident is prepared for discharge, as we do not have evidence that nursing facility discharge services via telehealth is adequately equivalent to face-to-face provision. As such, we are not proposing to add the nursing facility discharge day management services (as described by HCPCS codes 99315 and 99316) to the list of approved telehealth services.

Other Nursing Facility Service

In 2006, CPT added a procedure code for Other Nursing Facility Service (CPT code 99318) to describe an annual nursing facility assessment. An annual assessment is not one of the required visits under the long-term care regulations at § 483.40. For Medicare purposes, this code can be used in lieu of a Subsequent Nursing Facility Care code to report a Federally-mandated periodic personal visit furnished under § 483.40(c). An annual assessment visit billed using CPT code 99318 does not represent a distinct benefit service for Medicare Part B physician services, and it cannot be billed in addition to the required number of Federally-mandated periodic personal visits. Under Medicare Part B, we cover this procedure code if the visit fully meets the CPT code 99318 requirements for an annual nursing facility assessment and if such an annual assessment falls on the 60-day mandated visit cycle. We are not proposing to add the other nursing facility care services (as described by HCPCS code 99318) to the list of approved telehealth services because this code is payable by Medicare only if the visit is substituted for a Federally-mandated visit under § 483.40(c). As explained above, we believe all of the Federally-mandated periodic visits must be conducted in person.

Follow-up Inpatient Consultations

Prior to 2006, follow-up inpatient consultations (as described by CPT codes 99261 through 99263) were approved telehealth services. In 2006, the CPT Editorial Panel of the American Medical Association (AMA) deleted the codes for follow-up inpatient consultations. In the hospital setting, the AMA advised practitioners to bill for services that would previously have been billed as follow-up inpatient consultations using the procedure codes for subsequent hospital care (as described by CPT codes 99231 through 99233). In the nursing facility setting,

the AMA advised practitioners to bill for these services using the procedure codes for subsequent nursing facility care (as described by CPT codes 99307 through 99310).

In the CY 2008 PFS proposed rule (72 FR 38144) and subsequent final rule with comment period (72 FR 66250), we discussed a request from the ATA to add subsequent hospital care to the list of approved telehealth services. Because there was no method for practitioners to bill for follow-up consultations delivered via telehealth to hospital inpatients, the ATA requested that we add the subsequent hospital care codes to the list of Medicare approved telehealth services. We expressed our concern that subsequent hospital care codes describe a broader range of services than follow-up consultations, including some services that may not be appropriate to be furnished via telehealth. We committed to continue evaluating the issues.

In the CY 2009 PFS proposed rule (73 FR 38517), we proposed to create a new series of HCPCS codes for follow-up inpatient telehealth consultations. In the CY 2009 PFS final rule with comment period (73 FR 69745), we finalized our proposal to create follow-up inpatient telehealth consultation codes (as described by HCPCS codes G0406 through G0408) and added these G-codes to the list of Medicare telehealth services. These HCPCS codes are limited to the range of services included in the scope of the previous CPT codes for follow-up inpatient consultations, and the descriptions limit the use of such services for telehealth. (*See* the CMS Internet-Only Medicare Benefit Policy Manual, Pub. 100–02, Chapter 15, Section 270.2.1 and the Medicare Claims Processing Manual, Pub. 100–04, Chapter 12, Section 190.3.1 for the current definition of follow-up inpatient telehealth consultations.)

We note that if the former codes for follow-up consultations (as described by CPT codes 99261 through 99263) still existed, these procedure codes would also be available to practitioners to submit claims to their Medicare contractors for payment of follow-up consultations provided via telehealth to patients located in SNFs. Although we did not receive a public request to add follow-up inpatient consultations for patients in SNFs to the list of approved Medicare telehealth services, we recognize a similar need to establish a method for practitioners to furnish and bill for follow-up consultations delivered via telehealth to patients in SNFs.

We considered the possibility of approving subsequent nursing facility care for telehealth with specific limitations, for example, approving subsequent nursing facility care for telehealth only when the codes are used for follow-up consultations. However, as discussed above, we do not believe it would be appropriate for E/M visits to be furnished via telehealth to treat residents of SNFs requiring medically complex care. We are concerned that it could be difficult to implement sufficient controls and monitoring to ensure that the use of the subsequent nursing facility care codes for telehealth is limited to the delivery of services that were formerly described as follow-up inpatient consultations.

We considered creating new G-codes to enable practitioners to bill for the services that were formerly described as follow-up inpatient telehealth consultations when furnished to residents of SNFs. We examined the feasibility of creating such codes to parallel the subsequent nursing facility care services, which are the codes currently used to bill these follow-up consultations in a face-to-face encounter. We found that the elements of the four levels of subsequent nursing facility care did not correspond to the three levels of the deleted CPT codes previously used for follow-up inpatient consultations. We believe that it would be administratively simpler to utilize the three existing codes for follow-up inpatient telehealth consultations rather than add additional G-codes. The use of the same ''follow-up inpatient telehealth consultation'' G-codes for services furnished in both hospital inpatient and SNF settings would also correspond to the use of the previous CPT codes for services furnished to hospital inpatients and residents of SNFs.

For CY 2010, we are proposing to revise § 410.78 to specify that the G-codes for follow-up inpatient telehealth consultations (as described by HCPCS codes G0406 through G0408) include follow-up telehealth consultations furnished to beneficiaries in hospitals and SNFs. The HCPCS codes will clearly designate these services as follow-up consultations provided via telehealth, and not subsequent nursing facility care used for E/M visits. Utilization of these codes for patients in SNFs will facilitate payment for these services, as well as enable us to monitor whether the codes are used appropriately.

As described in the CMS Internet-Only Medicare Benefit Policy Manual, Pub. 100–02, Chapter 15, Section 270.2.1 and the Medicare Claims Processing Manual, Pub. 100–04, Chapter 12, Section 190.3.1, follow-up inpatient telehealth consultations include monitoring progress, recommending management modifications, or advising on a new plan of care in response to changes in the patient's status or no changes on the consulted health issue. Counseling and coordination of care with other providers or agencies is included as well, consistent with the nature of the problem(s) and the patient's needs. The physician or practitioner who furnishes the inpatient follow-up consultation via telehealth cannot be the physician of record or the attending physician, and the follow-up inpatient consultation would be distinct from the follow-up care provided by a physician of record or the attending physician. If a physician consultant has initiated treatment at an initial consultation and participates thereafter in the patient's ongoing care management, such care would not be included in the definition of a follow-up inpatient consultation and is not appropriate for delivery via telehealth.

Consistent with our policy for follow-up telehealth consultations furnished to hospital inpatients, in order to bill and receive payment for these services, physicians and practitioners must submit the appropriate HCPCS procedure code for follow-up inpatient telehealth consultations along with the ''GT'' modifier (''via interactive audio and video telecommunications system''). By coding and billing the ''GT'' modifier with the follow-up inpatient telehealth consultation codes, the distant site physician or practitioner certifies that the beneficiary was present at an eligible originating site when the telehealth service was furnished. (*See* the CMS Internet-Only Medicare Claims Processing Manual, Pub. 100–04, Chapter 12, Section 190.6.1 for instructions for submission of interactive telehealth claims.)

In the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii, store and forward technologies may be used as a substitute for an interactive telecommunications system. Covered store and forward telehealth services are billed with the ''GQ'' modifier, ''via asynchronous telecommunications system.'' By using the ''GQ'' modifier, the distant site physician or practitioner certifies that the asynchronous medical file was collected and transmitted to him or her at the distant site from a Federal telemedicine demonstration project conducted in Alaska or Hawaii. (*See* the CMS Internet-Only Medicare Claims Processing Manual, Pub. 100–04, Chapter 12, Section 190.6.2 for instructions for submission of telehealth store and forward claims.)

c. Critical Care Services

In the CY 2009 PFS proposed rule (73 FR 38517), we reviewed a request submitted by the University of Pittsburgh Medical Center (UPMC) to add critical care services (as described by HCPCS codes 99291 and 99292) to the list of approved telehealth services. UPMC drew analogies to the E/M consultation services currently approved for telehealth and described how it uses telehealth to give stroke patients timely access to consultative input from highly specialized physicians who are not available to furnish services face-to-face.

In the CY 2009 PFS final rule with comment period (73 FR 69744), we did not add critical care services to the list of approved telehealth services. This request was not considered as a category #1 request because, as we stated, we believe that remote critical care services are a different service than the telehealth delivery of critical care (as described by HCPCS codes 99291 and 99292). We stated that we had no evidence suggesting that the use of telehealth could be a reasonable surrogate for the face-to-face delivery of this type of care, and we did not add critical care services to the list of Medicare approved telehealth services. We noted that this decision does not preclude physicians from providing telehealth consultations to critically ill patients.

Following publication of the CY 2009 PFS final rule with comment period, Philips Healthcare, the maker of a remote critical care system, submitted an expanded request to add critical care services to the list of Medicare approved telehealth services. The Philips Healthcare request stated that critical care services can be approved as a Category #1 service based on their similarity to the inpatient consultation services currently approved for telehealth. The requester noted that many of the components of critical care are similar to a high-level inpatient consultation service, which is currently approved for telehealth. Common components include obtaining a patient history, conducting an examination, and engaging in complex medical decision-making for patients who may be severely ill. Because we classified critical care as a Category #2 service last year, Philips also submitted evidence to support its belief that the use of telehealth could be a reasonable surrogate for the face-to-face delivery of this type of care.

CMS Review

To determine whether to assign a request to Category #1, we look for similarities between the service that is being considered for addition and existing telehealth services for the roles of, and interactions among, the beneficiary, the physician (or other practitioner) at the distant site and, if necessary, the telepresenter. In this case, we look for such similarities between critical care and inpatient consultations and other similar services on the current list of approved Medicare telehealth services. Critical care (as described by HCPCS codes 99291 and 99292) is the direct delivery by a physician of medical care for a critically ill or critically injured patient. It involves high complexity decision-making to assess, manipulate, and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life-threatening deterioration of the patient's condition. Within the current standards of practice, we believe critical care services require the physical presence of the physician rendering the critical care services. We also note that a number of hands-on interventions (for example, gastric intubation and vascular access procedures), when furnished on the day a physician bills for critical care, are included in the critical care service and are not reported separately. Inpatient consultations generally do not include hands-on interventions. Because we believe that critical care services (as described by HCPCS codes 99291 and 99292) require the physical presence of a physician who is available to furnish any necessary hands-on interventions, we do not consider critical care services similar to any services on the current list of Medicare telehealth services. Therefore, we believe critical care must be evaluated as a Category #2 service.

In order to evaluate critical care services as a Category #2 service, we need to determine whether these are services for which telehealth can be an adequate substitute for a face-to-face encounter. In CPT 2009, the AMA defined remote critical care services tracking codes (codes 0188T through 0189T) with cross-references to critical care services (HCPCS codes 99291 through 99292). CPT directs that only one physician may report either critical care services or remote critical care services for the same period. The requester cites this as evidence that the AMA considers the two services equivalent, and that critical care should be approved as a Category #2 service. We do not consider the CPT coding guidance persuasive evidence that remote critical care is the telehealth delivery of critical care, as defined by HCPCS codes 99291 and 99292. We believe that if the AMA valued the two services equally, they would not have created separate tracking codes for remote critical care services.

As we noted in the CY 2009 PFS final rule with comment period, consistent with the AMA's creation of tracking codes, we believe that remote critical care services are different from the telehealth delivery of critical care services (as described by HCPCS codes 99291 and 99292). Category III CPT codes track utilization of a service, facilitating data collection on, and assessment of, new services and procedures. We believe that the data collected for these tracking codes will help provide useful information on how to best categorize and value remote critical care services in the future.

The requester also submitted studies which conclude that remote critical care services furnished by intensivists improve mortality rates, decrease length of stay, reduce per patient costs, and improve compliance with best practices, thereby improving patient outcomes. These studies are similar to the ones we received and reviewed from the CY 2009 PFS proposed rule. We maintain that remote critical care services are not the telehealth delivery of critical care services (as described by HCPCS codes 99291 and 99292). Therefore, we do not find the new studies submitted with the CY 2010 request persuasive that telehealth can be an adequate substitute for the face-to-face delivery of critical care services (as described by HCPCS codes 99291 and 99292).

We continue to believe that remote critical care services are different services than the telehealth delivery of critical care (as described by HCPCS codes 99291 and 99292). As such, we are not proposing to add critical care services (as described by HCPCS codes 99291 and 99292) to the list of approved telehealth services. We reiterate that our decision not to add critical care services to the list of approved telehealth services does not preclude physicians from furnishing telehealth consultations to critically ill patients.

d. Other Requests

We received a number of requests to add services that we reviewed and did not approve in previous PFS Rules. The following are brief summaries and references to previous discussions regarding our decisions not to add these procedure codes to the list of Medicare approved telehealth services. As explained further below, we are not reconsidering these previous decisions.

Initial and Subsequent Hospital Care

We received a request to add initial hospital care (as described by HCPCS codes 99221 through 99223) and subsequent hospital care (as described by HCPCS codes 99231 through 99233) to the list of approved telehealth services. In response to previous requests, we did not add initial or subsequent hospital care to the list of approved telehealth services because of our concern regarding the use of telehealth for the ongoing E/M of a high-acuity hospital inpatient. (*See* 69 FR 47510 and 66276, 72 FR 38144 and 66250, and 73 FR 38517 and 69745.) We did not receive any new information with this request that would alter our previous decisions. Therefore, we are not proposing to add initial hospital care (as described by HCPCS codes 99221 through 99223) or subsequent hospital care (as described by HCPCS codes 99231 through 99233) to the list of approved telehealth services.

Group Medical Nutrition Therapy Services

We received a request to add group medical nutrition therapy (MNT) services (as described by HCPCS codes G0271 and 97804) to the list of approved telehealth services. In response to a previous request, we did not add group MNT to the list of approved telehealth services because we believe that group services are not appropriately delivered through telehealth. (*See* 70 FR 45787 and 70157.) We did not receive any new information with this request that would alter our previous decision. Therefore, we are not proposing to add group MNT (as described by HCPCS codes G0271 and 97804) to the list of approved telehealth services.

Diabetes Self-Management Training (DSMT)

We received a request to add diabetes self-management training (DSMT) (as described by HCPCS codes G0108 and G0109) to the list of approved telehealth services. In response to previous requests, we did not add DSMT to the list of approved telehealth services because of the statutory requirement that DSMT include teaching beneficiaries to self-administer injectable drugs. Furthermore, DSMT is often performed in group settings and we believe that group services are not appropriately delivered through telehealth. (*See* 70 FR 45787 and 70157, and 73 FR 38516 and 69743.) We did not receive any new information with this request that would alter our previous decisions. Therefore, we are not proposing to add DSMT (as described by HCPCS codes G0108 and G0109) to the list of approved telehealth services.

Speech and Language Pathology Services

We received a request to add various speech and language pathology services to the list of approved telehealth services. Speech-language pathologists are not permitted under current law to furnish and receive payment for Medicare telehealth services. Therefore, we do not propose to add any speech and language pathology services to the list of Medicare telehealth services. (For further discussion, *see* 69 FR 47512 and 66276, and 71 FR 48995 and 69657.)

Physical and Occupational Therapy Services

We received a request to add various physical and occupational therapy services to the list of approved telehealth services. Physical and occupational therapists are not permitted under current law to furnish and receive payment for Medicare telehealth services. Therefore, we are not proposing to add any physical and occupational therapy services to the list of approved telehealth services. (For further discussion, *see* 71 FR 48995 and 69657.)

E. Coding Issues

1. Canalith Repositioning

In 2008, the CPT Editorial Panel created a new code for canalith repositioning (CRP). This procedure is a treatment for vertigo which involves therapeutic maneuvering of the patient's body and head in order to use the force of gravity to redeposit the calcium crystal debris in the semicircular canal system.

In the CY 2009 PFS final rule with comment period (73 FR 69896), new CPT code 95992, *Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day*, was assigned the bundled status indicator (B). We explained that this procedure previously was billed as part of an evaluation and management (E/M) service or under a number of CPT codes, including CPT code 97112, *Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities.* We also explained that because neurologists and therapists are the predominant providers of this service to Medicare patients (each at 22 percent), it was assigned as a ''sometimes therapy'' service under the therapy code abstract file.

We received comments on this issue from the American Physical Therapy Association (APTA), as well as other organizations expressing opposition to our decision to bundle the new code. Commenters stated that they believe that our decision to bundle CPT code 95992 is flawed since physical therapists are unable to bill E/M services. The commenter also stated that therapists would be precluded from using another code for billing for this service because CPT correct coding instructions require that the provider/supplier select the procedure that most accurately defines the service provided. Commenters also expressed concern that this could impact beneficiary access to this service.

Based upon the commenters' feedback, we realized that we had failed to address how therapists would bill for the service since they cannot bill E/M services. In order to address this situation so that access to this service would not be impacted, we included language in a change request (CR) (the quarterly update CR for April) and also released a MedLearn article informing PTs to continue using one of the more generally defined ''always therapy'' CPT codes (97112) as a temporary measure. *See http://www.cms.hhs.gov/transmittals/downloads/R1691CP.pdf* and *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6397.pdf*.

In response to the concerns raised and upon additional review of this issue for CY 2010, we are proposing to change the status indicator from B (Bundled) to I (Invalid). We propose that physicians would continue to be paid for CRP as a part of an E/M service. Physical therapists would continue to use one of the more generally defined ''always therapy'' CPT codes (97112). We believe that this will enable beneficiaries to continue to receive this service while at the same time it will address our concerns about the potential for duplicate billing for this service to the extent that this service is paid as a part of an E/M service. As a result of this proposal, CPT code 95992 would be removed as a ''sometimes'' therapy code from the therapy code list.

2. Payment for an Initial Preventive Physical Examination (IPPE)

Beginning January 1, 2010, we propose to increase the payment for an initial preventive physical examination (IPPE) furnished face-to-face with the patient and billed with HCPCS code G0402, *Initial preventive physical examination; face-to-face visit, services*

limited to new beneficiary during the first 12 months of Medicare enrollment. The IPPE service includes a broad array of components and focuses on primary care, health promotion, and disease prevention.

Section 101(b) of the MIPPA changed the IPPE benefit by adding to the IPPE visit the measurement of an individual's body mass index and, upon an individual's consent, end-of-life planning. Section 101(b) of the MIPPA also removed the screening electrocardiogram (EKG) as a mandatory service of the IPPE.

In order to implement this MIPPA provision, in the CY 2009 PFS final rule with comment period (73 FR 69870), we created HCPCS code G0402 as a new HCPCS code and retained, on an interim basis, the work RVUs of 1.34 assigned to HCPCS code G0344, the code that was previously used to bill for the IPPE. While we did not believe the revisions to the IPPE required by MIPPA impacted the work RVUs associated with this service, we solicited public comments on this issue, as well as suggested valuations of this service to reflect resources involved in furnishing the service.

We received comments from several medical groups representing primary care physicians and geriatricians, as well as comments from the American Medical Association concerning this issue. The commenters stated that the IPPE service was undervalued prior to the addition of components by the MIPPA. Commenters also stated that the current level of work RVUs would discourage delivery of appropriate end-of-life planning with the beneficiary. One commenter suggested the work associated with HCPCS code G0402 for the IPPE, as described in statute, is captured in existing CPT code 99387, *Preventive Medicine Service, new patient, Initial comprehensive preventive medicine, 65 years and older.* (This code is not paid under the PFS.) The work RVUs for this CPT code are 2.06.

Based on a review of the comments and upon further evaluation of the component services of the IPPE, we believe the services, in the context of work and intensity, contained in HCPCS code G0402 are most equivalent to those services contained in CPT code 99204, *Evaluation and management new patient, office or other outpatient visit*, and propose increasing the work RVUs for HCPCS code G0402 to 2.30 effective for services furnished beginning on January 1, 2010.

3. Audiology Codes: Policy Clarification of Existing CPT Codes

In the CY 2009 PFS final rule with comment period (73 FR 69890), we noted that the RUC reviewed and recommended work RVUs for 6 audiology codes with which we agreed (that is, CPT codes 92620, 92621, 92625, 92626, 92627, and 92640). We also noted that in the Medicare program, audiology services are provided under the diagnostic test benefit and that some of the work descriptors for these services include ''counseling,'' ''potential for remediation,'' and ''establishment of interventional goals.'' We noted that we do not believe these aspects fit within the diagnostic test benefit, and therefore, we solicited comment on this issue.

Since audiology services fall under the diagnostic test benefit, aspects of services that are therapeutic or management activities are not payable to audiologists. This distinction is of particular importance since CPT codes 92620, 92621, 92626, 92627, and 92640 are ''timed'' codes, that is, these codes are billed based on the actual time spent furnishing the service. In response to our request, the society that represents speech language pathologists, audiologists, and speech and language scientists, provided the following comments.

Comment: With respect to the term ''counseling,'' the commenter stated that ''counseling'' as used in the intraservice work description for CPT code 92640, *Diagnostic analysis with programming of auditory brainstem implant, per hour*, is used in the context of informational rather than personal counseling. In this instance the counseling provides information and guidance to the patient on what to expect relative to the service (application of the electrical stimulation). This counseling is an integral part of the diagnostic procedure and not a means of providing therapy or active treatment.

Response: We appreciate the comments related to counseling by the specialty society, but are not persuaded that counseling is an integral part of a diagnostic test. Although we understand that test results are sometimes conveyed to the patient during or at the conclusion of a diagnostic test, counseling the patient about how to compensate for a hearing loss is part of a therapeutic service. As such, therapeutic and/or management of disease process counseling are not part of the diagnostic test benefit and time attributable to such activities is not payable to audiologists under the Medicare program.

Comment: With respect to the term ''potential for remediation,'' which is found as part of the intraservice work descriptor for CPT code 92625, *Assessment of tinnitus* (*includes pitch, loudness matching, and masking*), the commenter states that the procedure evaluates the frequency and intensity characteristics of the perceived tinnitus in addition to measuring how the tinnitus responds to a masking noise. The response to masking noise is diagnostic information that audiologists and physicians refer to as the ''potential for remediation.'' This assessment is thus a part of a complete diagnostic workup and is not a treatment or therapeutic service.

Response: The intraservice work for this service includes informing the patient of the outcome of the evaluation and the potential for remediation. As noted above, although we understand that test results are sometimes conveyed to the patient during or at the conclusion of a diagnostic test, discussing therapeutic options and/or providing therapy or management based on test results are not part of a diagnostic test. Discussing the potential for remediation does not appear to be part of a diagnostic test. While this service can involve a small amount of nondiagnostic work, CPT code 92625 is not a timed code and the bulk of the work described in the code appears to be diagnostic in nature.

Comment: With respect to the term ''establishment of interventional goals,'' this phrase is found in the intraservice work description of CPT code 92626, *Evaluation of auditory rehabilitation status; first hour.* The commenter states that this procedure focuses on diagnostic information relative to the patient's ability to use residual hearing with a hearing aid, a cochlear implant, or with no electronic device. The intervention goals may take a variety of forms, such as the following: Meeting audiological criteria for cochlear implantation; a recommendation to continue use of hearing aids (that is, not a cochlear implant candidate); and the need to coordinate with a speech-language pathologist for auditory training. This provides the physician with a complete diagnostic evaluation of the patient's residual hearing status. There is no element of therapy or treatment associated with this service.

Response: Diagnostic testing usually does not involve the establishment of interventional goals. The test report usually contains test findings and may suggest additional tests. While we appreciate the comments of the specialty society, we are not persuaded that establishing interventional goals is

part of a diagnostic test under Medicare. The establishment of interventional goals is clearly a function of therapeutic management. As such, establishment of goals is not part of the diagnostic test benefit and time attributable to such activity is not payable to an audiologist under the Medicare program.

We appreciate the comments we received on this issue. We want to emphasize that therapeutic and/or management activities associated with these audiology tests are not payable to audiologists because of the benefit category under which these tests are covered. We may also issue instructions to contractors to monitor these services to prevent inappropriate payments.

4. Consultation Services

a. Background

The current physician visit and consultation codes were developed by the American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel in November 1990. A consultation service is an evaluation and management (E/M) service furnished to evaluate and possibly treat a patient's problem(s). It can involve an opinion, advice, recommendation, suggestion, direction, or counsel from a physician or qualified NPP at the request of another physician or appropriate source. (*See* the Internet-Only Medicare Claims Processing Manual, Pub. 100–04, chapter 12, § 30.6.10A for more information.) A consultation service must be documented and a written report given to the requesting professional. Currently, consultation services are predominantly billed by specialty physicians. Primary care physicians infrequently furnish these services.

The required documentation supports the accuracy and medical necessity of a consultation service that is requested and provided. Medicare pays for a consultation service when the request and report are documented as a consultation service, regardless of whether treatment is initiated during the consultation evaluation service. (*See* the Internet-Only Medicare Claims Processing Manual, Pub. 100–04, chapter 12, § 30.6.10B.) A consultation request between professionals may be done orally by telephone, face-to-face, or by written prescription brought from one professional to another by the patient. The request must be documented in the medical record.

In the Physician Fee Schedule Final Rule issued June 5, 1991, (56 FR 25828) we stated that the agency's goal for the development of the new visit and consultation codes was that they meet two criteria: (1) They should be used reliably and consistently by all physicians and carriers; that is, the same service should be coded the same way by different physicians; and (2) they should be defined in a way that enables us to properly crosswalk the new codes to the relative values for the Harvard vignettes so valid RVUs for work are assigned to the new codes.

Based on requests from the physician community to clarify our consultation payment policy and to provide consultation examples, we convened an internal workgroup of medical officers within CMS (then called the Health Care Financing Administration, or HCFA) and revised the payment policy instructions in August 1999 in the Medicare Claims Processing Manual (at § 30.6.10 as cited above). We provided examples of consultation services and examples of clinical scenarios that did not satisfy Medicare criteria for consultation services. Without explicit instructions for every possible clinical scenario outlined in national policy instructions or in AMA coding definitions or coding instructions, the local policy interpretations by Medicare contractors were not universally equivalent or acceptable to the physician community and resulted in denials in different localities. Some Medicare contractors would consider a consultation service with treatment to be an initial visit rather than a consultation thus resulting in a denial for the billed consultation. We clarified in the 1999 revision that Medicare would pay for a consultation whether treatment was initiated at the consultation visit or not. The physician community has stated that terms such as referral, transfer and consultation, used interchangeably by physicians in clinical settings, confuse the actual meaning of a consultation service and that interpretation of these words varies greatly among members of that community as some label a transfer as a referral and others label a consultation as a referral. Although we clarified the terms referral and consultation in the 1999 revision, there was disagreement with our policy by physicians in the health care community and by AMA CPT staff. We provided our documentation guidance so physicians would be in compliance with our payment policy. The consultation definition in the AMA CPT simply stated that the consultant's opinion or other information must be communicated to the requesting physician.

Additional manual revisions in both January and September 2001 (at § 30.6.10 as cited above) clarified that NPPs can both request and furnish consultation services within their scope of practice and licensure requirements. We continued to explain our documentation requirements to the physician community through our Medicare contractors and in our discussions with the AMA CPT staff. Under our current policy and in the AMA CPT definition, a consultation service must have a request from another physician or other professional and be followed by a report to the requesting professional. The AMA CPT definition does not state the request must be written in the requesting physician's medical record. However, we require the request to be documented in the requesting physician's plan of care in the medical record as a condition for Medicare payment. The E/M documentation guidelines which apply to all E/M visits or consultations (*http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp*) clearly state that when referrals are made, consultations are requested, or advice is sought, the medical record should indicate to whom and where the referral or consultation is made or from whom the advice is requested. Our Medicare contractors are responsible for reviewing and paying consultation claims when submitted. When there is a question that triggers a review of a consultation service, our Medicare contractors will look at both the requesting physician's medical record (where the request should be noted) and the consultant's medical record where the consultation is reported and at the report generated for the requesting physician. Medicare contractors do not look for evidence of documentation on every claim, only when there is a concern raised during random sampling or during a specific audit performed by a contractor. The AMA CPT coding manual, which is not a payment manual, does not specify these requirements, and, therefore, as we understand it, many physicians do not agree with the CMS policy.

In March 2006, the Office of the Inspector General (OIG) published a report entitled, ''Consultations in Medicare: Coding and Reimbursement'' (OEI–09–02–00030). The purpose of the report was to assess whether Medicare's payments for consultation services were appropriate. While the OIG study was being conducted, we continued our ongoing discussions with the AMA CPT staff for potential changes to the consultation definition and guidance in CPT. The findings in the OIG report (based on claims paid by Medicare in 2001) indicated that Medicare allowed

approximately $1.1 billion more in 2001 than it should have for services that were billed as consultations. Approximately 75 percent of services paid as consultations did not meet all applicable program requirements (per the Medicare instructions) resulting in improper payments. The majority of these errors (47 percent of the claims reviewed) were billed as the wrong type or level of consultation. The second most frequent error was for services that did not meet the definition of a consultation (19 percent of the claims reviewed). The third category of improperly paid claims was a lack of appropriate documentation (9 percent of the claims reviewed). The OIG recommended that CMS, through our Medicare contractors, should educate physicians and other health care practitioners about Medicare criteria and proper billing for all types and levels of consultations with emphasis on the highest levels and follow-up inpatient consultation services.

We agreed with the OIG findings that additional education would help physicians understand the differences in the requirements for a consultation service from those for other E/M services. With each additional revision from 1999 until the OIG study began, we continually educated physicians through the guidance provided by our Medicare contractors. However, there remained discrepancies with unclear and ambiguous terms and instructions in the AMA CPT consultation coding definition, transfer of care and documentation, and the feedback from the physician community indicated they disagreed with Medicare guidance.

Prior to the official publication of the OIG report, we issued a Medlearn Matters article, effective January 2006, to educate the physician community about requirements and proper billing for all types and levels of consultation services as requested by the OIG in their report. The Medlearn Matters article reflected the manual changes we made in 2006 and the AMA CPT coding changes as noted below.

Our consultation policy revisions continued as a work-in-progress over several years as disagreements were raised by the physician community. We continued to work with AMA CPT coding staff in an attempt to have improved guidance for consultation services in the CPT coding definition. In looking at physician claims data (for example, the low usage of confirmatory consultation services) and in response to concerns from the physician community regarding how to correctly use the follow-up consultation codes, the AMA CPT Editorial Panel chose to delete some of the consultation codes for 2006. The Follow-Up Inpatient Consultation codes (CPT codes 99261 through 99263) and the Confirmatory Consultation codes (CPT codes 99271 through 99275) were deleted. During our ongoing discussions, the AMA CPT staff, maintained that physicians did not fully understand the use of these codes and historically submitted them inappropriately for payment as was reflected in the OIG study.

We issued a manual revision in the Medicare Claims Processing Manual (at § 30.6.10 as cited above) simultaneously with the publication of AMA CPT 2006 coding changes removing the follow-up consultation codes, and instructed physicians to use the existing subsequent hospital care code(s) and subsequent nursing facility care codes for visits following a consultation service. The confirmatory consultation codes (which were typically used for second opinions) were also removed and we instructed physicians to use the existing E/M codes for a second opinion service. We further clarified the documentation requirements by making it easier to document a request for a consultation service from another physician and to submit a consultation report to the requesting professional. Again, physicians stated that a consultant has no control over what a requesting or referring physician writes in a medical record, and that they should not be penalized for the behavior of others. However, our consultation policy instructions apply to all physicians, whether they request a consultation or furnish a consultation. As noted above, documentation by both the requesting physician and the physician who furnishes the consultation, is required under the E/M documentation guidelines. The E/M documentation guidelines have been in use since 1995. In our discussions with the AMA CPT staff and physician groups, and national physician open door conference calls, we have emphasized that the requesting physician medical record is not reviewed unless there is a specific audit or random sampling performed. The physician furnishing the consultation service should document in the medical record from whom a request is received.

We continue to hear from the AMA and from specific national physician specialty representatives that physicians are dissatisfied with Medicare documentation requirements and guidance that distinguish a consultation service from other E/M services such as transfer of care. CPT has not clarified transfer of care. Therefore, many physician groups disagree with our requirements for documentation of transfer of care. Interpretation differs from one physician to another as to whether transfer of care should be reported as an initial E/M service or as a consultation service.

Despite our efforts, the physician community disagrees with Medicare interpretation and guidance for documentation of transfer of care and consultation. The existing consultation coding definition in the AMA CPT definition remains ambiguous and confusing for certain clinical scenarios and without a clear definition of transfer of care. The CPT consultation codes are used by physicians and qualified NPPs to identify their services for Medicare payment. There is an absence of any guidance in the AMA CPT consultation coding definition that distinguishes a transfer of care service (when a new patient visit is billed) from a consultation service (when a consultation service is billed). Medicare does provide guidance although there is disagreement with our policy from AMA CPT staff and some members of the physician community. Because of the disparity between AMA coding guidance and Medicare policy some physicians state they have difficulty in choosing the appropriate code to bill. The payment for both inpatient consultation and office/outpatient consultation services is higher than for initial hospital care and new patient office/outpatient visits. However, the associated physician work is clinically similar. Many physicians contend that there is more work involved with a new patient visit than a consultation service because of the post work involvement with a new patient. The payment for a consultation service has been set higher than for initial visits because a written report must be made to the requesting professional. However, all medically necessary Medicare services require documentation in some form in a patient's medical record. Over the past several years, some physicians have asked CMS to recognize the provision of the consultation report via a different form of communication in lieu of a written letter report to the requesting physician so as to lessen any paperwork burden on physicians. We have eased the consultation reporting requirements by lessening the required level of formality and permitting the report to be made in any written form of communication, (including submission of a copy of the evaluation examination taken directly from the medical record and submitted without a letter format) as long as the identity of the physician who furnished the consultation is

evident. Although preparation and submission of the consultant's report is no longer the major defining aspect of consultation services, the higher payment has remained. (*See* the Internet-Only Medicare Claims Processing Manual, Pub. 100–04, chapter 12, § 30.6.10 F.)

Both AMA CPT coding rules and Medicare Part B payment policy have always required that there is only one admitting physician of record for a particular patient in the hospital or nursing facility setting. (AMA CPT 2009, Hospital Inpatient Services, Initial Hospital Care, p.12) This physician has been the only one permitted to bill the initial hospital care codes or initial nursing facility codes. All other physicians must bill either the subsequent hospital care codes, subsequent nursing facility care codes or consultation codes. (*See* the Internet-Only Medicare Claims Processing Manual, Pub. 100–04, chapter 12, § 30.6.9.1 G.)

Beginning January 1, 2008, we ceased to recognize office/outpatient consultation CPT codes for payment of hospital outpatient visits (72 FR 66790 through 66795). Instead, we instructed hospitals to bill a new or established patient visit CPT code, as appropriate to the particular patient, for all hospital outpatient visits. Regardless of all of our efforts to educate physicians on Medicare guidance for documentation, transfer of care, and consultation policy, disagreement in the physician community prevails.

b. Proposal

Beginning January 1, 2010, we propose to budget neutrally eliminate the use of all consultation codes (inpatient and office/outpatient codes for various places of service except for telehealth consultation G-codes) by increasing the work RVUs for new and established office visits, increasing the work RVUs for initial hospital and initial nursing facility visits, and incorporating the increased use of these visits into our PE and malpractice RVU calculations.

We note that section 1834(m) of the Act includes ''professional consultations'' (including the initial inpatient consultation codes ''as subsequently modified by the Secretary'') in the definition of telehealth services. We recognize that consultations furnished via telehealth can facilitate the provision of certain services and/or medical expertise that might not otherwise be available to a patient located at an originating site. Therefore, for CY 2010, if we finalize our proposed policy to eliminate consultations from the PFS, then we propose to create HCPCS codes specific to the telehealth delivery of initial inpatient consultations. The purpose of these codes would be solely to preserve the ability for practitioners to provide and bill for initial inpatient consultations delivered via telehealth. These codes are intended for use by practitioners when furnishing services that meet Medicare requirements relating to coverage and payment for telehealth services. Practitioners would use these codes to submit claims to their Medicare contractors for payment of initial inpatient consultations provided via telehealth. The new HCPCS codes would be limited to the range of services included in the scope of the CPT codes for initial inpatient consultations, and the descriptions would be modified to limit the use of such services for telehealth. The HCPCS codes would clearly designate these as initial inpatient consultations provided via telehealth, and not initial hospital care or initial nursing facility care used for inpatient visits. Utilization of these codes would allow us to provide payment for these services, as well as enable us to monitor whether the codes are used appropriately.

If we create HCPCS G-codes specific to the telehealth delivery of initial inpatient consultations, then we also propose to crosswalk the RVUs for these services from the RVUs for initial hospital care (as described by CPT codes 99221 through 99223). We believe this is appropriate because a physician or practitioner furnishing a telehealth service is paid an amount equal to the amount that would have been paid if the service had been furnished without the use of a telecommunication system. Since physicians and practitioners furnishing initial inpatient consultations in a face-to-face encounter to hospital inpatients must continue to utilize initial hospital care codes (as described by CPT codes 99221 through 99223), we believe it is appropriate to set the RVUs for the proposed inpatient telehealth consultation G-codes at the same level as for the initial hospital care codes.

We considered creating separate G-codes to enable practitioners to bill initial inpatient telehealth consultations when furnished to residents of SNFs and crosswalking the RVUs to initial nursing facility care (as described by CPT codes 99304 through 99306). For the sake of administrative simplicity, if we create HCPCS G-codes specific to the telehealth delivery of initial inpatient consultations, they will be defined in § 410.78 and in our manuals as appropriate for use to deliver care to beneficiaries in hospitals or skilled nursing facilities. If we adopt this proposal, then we will make corresponding changes to our regulations at § 410.78 and § 414.65. In addition, we will add the definition of these codes to the CMS Internet-Only Medicare Benefit Policy Manual, Pub. 100–02, Chapter 15, Section 270 and the Medicare Claims Processing Manual, Pub. 100–04, Chapter 12, Section 190.

Outside the context of telehealth services, physicians will bill an initial hospital care or initial nursing facility care code for their first visit during a patient's admission to the hospital or nursing facility in lieu of the consultation codes these physicians may have previously reported. The initial visit in a skilled nursing facility and nursing facility must be furnished by a physician except as otherwise permitted as specified in § 483.40(c)(4). In the nursing facility setting, an NPP who is enrolled in the Medicare program, and who is not employed by the facility, may perform the initial visit when the State law permits this. (*See* this exception in the Internet-Only Medicare Claims Processing Manual, Pub. 100–04, chapter 12, § 30.6.13A). An NPP, who is enrolled in the Medicare program is permitted to report the initial hospital care visit or new patient office visit, as appropriate, under current Medicare policy. Because of an existing CPT coding rule and current Medicare payment policy regarding the admitting physician, we will create a modifier to identify the admitting physician of record for hospital inpatient and nursing facility admissions. For operational purposes, this modifier will distinguish the admitting physician of record who oversees the patient's care from other physicians who may be furnishing specialty care. The admitting physician of record will be required to append the specific modifier to the initial hospital care or initial nursing facility care code which will identify him or her as the admitting physician of record who is overseeing the patient's care. Subsequent care visits by all physicians and qualified NPPs will be reported as subsequent hospital care codes and subsequent nursing facility care codes.

We believe the rationale for a differential payment for a consultation service is no longer supported because documentation requirements are now similar across all E/M services. To be consistent with OPPS policy, as noted above, we will pay only new and established office or other clinic visits under the PFS.

This proposed change would be implemented in a budget neutral

manner, meaning it would not increase or decrease PFS expenditures. We would make this change budget neutral for the work RVUs by increasing the work RVUs for new and established office visits by approximately 6 percent to reflect the elimination of the office consultation codes and the work RVUs for initial hospital and facility visits by approximately 2 percent to reflect the elimination of the facility consultation codes. We have crosswalked the utilization for the office consultation codes into the office visits and the utilization of the hospital and facility consultation codes into the initial hospital and facility visits. This change would be made budget neutral in the PE and malpractice RVU methodologies through the use of the new work RVUs and the crosswalked utilization. The PE and malpractice RVU methodologies are described elsewhere in this proposed rule.

We are soliciting comments on the proposal, described more fully above, to eliminate payment for all consultation services codes under the PFS and to allow all physicians to bill, in lieu of a consultation service code, an initial hospital care visit or initial nursing facility care visit for their first visit during a patient's admission to the hospital or nursing facility. Additionally, we are soliciting comments on the proposal to create HCPCS G-codes to identify the telehealth delivery of initial inpatient consultations.

F. Potentially Misvalued Services Under the Physician Fee Schedule

1. Valuing Services Under the Physician Fee Schedule

The American Medical Association's (AMA) Relative Value System Update Committee (RUC) provides recommendations to CMS for the valuation of new and revised codes, as well as codes identified as misvalued. On an ongoing basis, the AMA RUC's Practice Expense (PE) Subcommittee reviews direct PE (clinical staff, medical supplies, medical equipment) for individual services and examines the many broad and methodological issues relating to the development of PE relative value units (RVUs).

To address concerns expressed by stakeholders with regard to the process we use to price services paid under the PFS, the AMA RUC created the Five-Year Review Identification Workgroup. As we stated in the CY 2009 PFS proposed rule (73 FR 38582), the workgroup identified some potentially misvalued codes through several vehicles, namely, identifying codes with site of service anomalies, high intra-service work per unit time (IWPUT), and services with high volume growth. The IWPUT is derived from components of the ''building-block'' approach, as described in the CY 2007 PFS proposed rule (71 FR 37172), and is used as a measure of service intensity. There were 204 services identified as misvalued last year and we plan to continue working with the AMA RUC to identify additional codes that are potentially misvalued. In the CY 2009 PFS proposed rule (73 FR 38586), we also listed approaches for the AMA RUC to utilize, namely, the review of the fastest growing procedure codes, review of Harvard-valued codes, and review of PE RVUs.

We plan to address the AMA RUC's recommendations from the February and April 2009 meetings for codes with site of service anomalies in the CY 2010 PFS final rule with comment period in a manner consistent with the way we address other AMA RUC recommendations. Specifically, we complete our own review of the AMA RUC recommendations; and then in the PFS final rule with comment period, we describe the AMA RUC's recommendations, indicate whether or not we accept them, and provide a rationale for our decision. The values for these services will be published as interim values for the next calendar year.

We believe that there are additional steps we can take to help address the issue of potentially misvalued services. In the CY 2009 PFS proposed rule, we identified approaches to address this issue including reviewing services often billed together and the possibility of expanding the multiple procedure payment reduction (MPPR) to additional nonsurgical procedures and the update of high cost supplies.

2. High Cost Supplies

In the CY 2009 PFS proposed rule (73 FR 38582), we proposed a process to update the prices associated with high cost supplies over $150 every 2 years. We explained that we would need the cooperation of the medical community in obtaining typical prices in the marketplace. We also outlined examples of acceptable documentation. Although we received many thoughtful comments on the proposed process for updating high-cost supplies, as stated in the CY 2009 PFS final rule with comment period (73 FR 69882), we are continuing to examine alternatives on the best way to obtain accurate pricing information and will propose a revised process in future rulemaking.

3. Review of Services Often Billed Together and the Possibility of Expanding the Multiple Procedure Payment Reduction (MPPR) to Additional Nonsurgical Procedures

In the CY 2009 PFS final rule with comment period (73 FR 69882), we stated that we plan to perform a data analysis of nonsurgical CPT codes that are often billed together. This would identify whether there are inequities in PFS payments that are a result of variations between services in the comprehensiveness of the codes used to report the services, or in the payment policies applied to each (for example, global surgery and MPPRs). The rationale for the MPPR is that certain clinical labor activities, supplies, and equipment are not performed or furnished twice when multiple procedures are performed. We stated that we would consider developing a proposal either to bundle additional services or expand application of the MPPR to additional procedures.

Several specialty groups noted that the AMA RUC has already taken action to identify frequently occurring code pairs. The commenters support the AMA RUC's recommendation that CMS analyze data to identify nonsurgical CPT codes that are billed together 90 to 95 percent of the time. Additionally, the Medicare Payment Advisory Committee (MedPAC) requested that we consider duplicative physician work, as well as PE, in any expansion of the MPPR.

We plan to analyze codes furnished together more than 75 percent of the time, excluding E/M codes. We will analyze both physician work and PE inputs. If duplications are found, we will consider whether an MPPR or bundling of services is most appropriate. Any proposed changes will be made through rulemaking and be subject to public comment at a later date.

4. AMA RUC Review of Potentially Misvalued Codes

a. Site of Service Anomalies

The AMA RUC created the Five-Year Review Identification Workgroup to respond to concerns expressed by the MedPAC, the Congress, and other stakeholders regarding accurate pricing under the PFS. The workgroup identified potentially misvalued codes through several vehicles. For example, the workgroup focused on codes for which there have been shifts in the site of service (site of service anomalies), codes with a high intra-service work per unit of time (IWPUT), and codes that were high volume. There were 204 potentially misvalued services

identified in 2008 (*see* the CY 2009 PFS final rule with comment period (73 FR 69883)). These codes were reviewed by the AMA RUC and recommendations were submitted to CMS in 2008.

In the CY 2009 PFS final rule with comment period (73 FR 69883), we noted that although we would accept the AMA RUC valuation for these site of service anomaly codes for 2009, we recognized that many of them included deletion or modification of certain inputs such as hospital days, office visits, service times, and discharge day management services in the global period. We also indicated that we had concerns about the methodology used by the AMA RUC to review these services which may have resulted in removal of hospital days and deletion or reallocation of office visits without extraction of the associated RVUs from the valuation of the code. However, we stated that we believed the AMA RUC-recommended valuations were still a better representation of the resources used to furnish these services than the current ones. We also stated that we would continue to examine these codes and would consider whether it would be appropriate to propose additional changes in future rulemaking.

After further review of these codes, we believe it would be appropriate to propose further changes to several of the codes where the valuation has been adjusted to reflect changes in the site of service. Specifically, we are proposing changes to codes for which the AMA RUC review process deleted or reallocated pre-service and post service times, hospital days, office visits, and discharge day management services without the extraction of the associated RVUs.

We believe the AMA RUC-recommended values do not reflect the extraction of the RVUs associated with deleted or reallocated pre-service and post-service times, hospital days, office visits, and discharge day management services. Therefore, we have recalculated the work RVUs based upon the AMA RUC-recommended inputs (that is, changes in pre-service and post-service times and associated E/M services). The proposed work RVUs for each CPT code shown in Table 8 were recalculated using the pre-AMA RUC review work RVUs as a starting point, and adjusting them for the addition or extraction of pre-service and post-service times, inpatient hospital days, discharge day management services and outpatient visits as recommended by the AMA RUC. We used the following methodology:

1. For each CPT code noted in Table 8, we separated out each component (that is, pre-service time, intra-service time, post-service time, inpatient hospital day, discharge day management services, and outpatient visits) that comprised the entire work RVUs for the service.

2. We calculated the incremental difference between the pre-service and post-service time from before and after the AMA RUC review, and multiplied that difference by an IWPUT intensity factor of 0.0224, which is a constant in the IWPUT equation. For example, if the pre-service time prior to the AMA RUC review was 75 minutes and, following its review, the AMA RUC recommended an increase in pre-service time to 85 minutes, we multiplied the difference (10 minutes) by 0.0224 to determine the RVUs associated with the increase in pre-service time, and then added that number of RVUs to the pre-AMA RUC evaluation work RVU.

3. We then added or removed the work RVUs associated with the extraction or reallocation of each inpatient hospital day, outpatient visit or discharge day management service as appropriate. For example, assume that prior to the AMA RUC review a code was assigned:

- 1 inpatient hospital day (currently billed using CPT code 99231 and assigned 0.76 work RVUs);
- 1 discharge day management service (currently billed using CPT code 99238 and assigned 1.28 work RVUs); and
- 2 outpatient visits (currently billed using 99212 and assigned 0.45 work RVUs).

After the AMA RUC review, the inpatient hospital day and discharge day management service were removed. To account for the removal of these services, we would have subtracted 0.76 work RVUs (represents the removal of the work RVUs for 1 inpatient hospital day) and 1.28 work RVUs (represents the removal of the work RVUs for 1 discharge day management service) from the pre-AMA RUC review work RVUs in order to develop the CMS proposed work RVUs.

The methodology discussed above was used for each code noted in Table 8 and reflects the extraction of the RVUs associated with deleted or reallocated hospital days, office visits, discharge day management services, and pre-service and post-service times based upon the AMA RUC recommendations.

TABLE 8: CY 2010 CMS PROPOSED WORK RVUS

CPT code [1]	Descriptor	Pre-AMA RUC eval. work RVU	2009 AMA RUC recommended work RVU	2010 CMS proposed work RVU
21025	Excision of bone, lower jaw	11.07	9.87	7.23
23415	Release of shoulder ligament	10.09	9.07	10.64
25116	Remove wrist/forearm lesion	7.38	7.38	4.83
42440	Excise submaxillary gland	7.05	7.05	6.88
52341	Cysto w/ureter stricture tx	6.11	5.35	5.20
52342	Cysto w/up stricture tx	6.61	5.85	5.63
52343	Cysto w/renal stricture tx	7.31	6.55	6.55
52344	Cysto/uretero, stricture tx	7.81	7.05	6.83
52345	Cysto/uretero w/up stricture	8.31	7.55	8.51
52346	Cystouretero w/renal strict	9.34	8.58	9.02
52400	Cystouretero w/congen repr	10.06	8.66	8.25
52500	Revision of bladder neck	9.39	7.99	8.49
52640	Relieve bladder contracture	6.89	4.73	4.28
53445	Insert uro/ves nck sphincter	15.21	15.21	17.02
54410	Remove/replace penis prosth	16.48	15.00	16.01
54530	Removal of testis	9.31	8.35	8.65
57287	Revise/remove sling repair	11.49	10.97	10.36
62263	Epidural lysis mult sessions	6.41	6.41	6.04
62350	Implant spinal canal cath	8.04	6.00	1.29

TABLE 8: CY 2010 CMS PROPOSED WORK RVUS—Continued

CPT code [1]	Descriptor	Pre-AMA RUC eval. work RVU	2009 AMA RUC recommended work RVU	2010 CMS proposed work RVU
63650	Implant neuroelectrodes	7.57	7.15	4.18
63685	Insrt/redo spine n generator	7.87	6.00	4.27
64708	Revise arm/leg nerve	6.22	6.22	7.36
64831	Repair of digit nerve	10.23	9.00	9.74
65285	Repair of eye wound	14.43	14.43	14.43

[1] All CPT codes copyright 2008 American Medical Association.

Using the methodology described above, the adjustments to work RVUs for CPT codes 62355, 62360, 62361, 62362, and 62365 would result in negative valuation: 62355 = −1.96; 62360 = −2.31; 62361 = −2.42; 62362 = −2.46; and 62365 = −1.88. For these codes, we are requesting that the AMA RUC re-review the entire family of associated codes and in the interim will maintain the AMA RUC recommended values until a methodology is developed to address codes that result in negative valuation when the methodology described above is utilized.

In addition to the proposed revisions to the AMA RUC-recommended RVUs described above, we encourage the AMA RUC to utilize the building block methodology as described in the CY 2007 PFS proposed rule (71 FR 37172) in the future when revaluing codes with site of service anomalies. We recognize that the AMA RUC looks at families of codes and may assign RVUs based on a particular code ranking within the family. However, the relative value scale requires each service to be valued based on the resources used in furnishing the service.

We are also seeking public comment on alternative methodologies that could be utilized to establish work RVUs for codes that would have a negative valuation under the methodology we used for the proposed revisions to the AMA RUC-recommended values described above.

b. ''23-Hour'' Stay

For services that are performed in the outpatient setting and require a hospital stay of less than 24 hours, we consider this an outpatient service and recognize the additional time associated with the patient evaluation and assessment in the post-service period. We are requesting that the AMA RUC include the additional minutes in their recommendations to CMS. We do not believe the current minutes assigned in the post-service period accurately reflects the total time required for evaluation and assessment of the patient. We believe the use of E/M codes for services rendered in the post-service period for procedures requiring less than a 24-hour hospital stay would result in overpayment for pre-service and intraservice work that would not be provided. Therefore, we will not allow an additional E/M service to be billed for care furnished during the post procedure period when care is furnished for an outpatient service requiring less than a 24-hour hospital stay.

5. Establishing Appropriate Relative Values for Physician Fee Schedule Services

In MedPAC's March 2006 Report to Congress, MedPAC made a number of recommendations to improve the review of the relative values for PFS services. Since that time, we have taken significant action to improve the accuracy of the RVUs. As MedPAC noted in its recent March 2009 Report to Congress, ''CMS and the AMA RUC have taken several steps to improve the review process'' in the intervening years since those initial recommendations. Many of our efforts to improve the accuracy of RVUs have also resulted in substantial increases in the payments for primary care services, which was one of the motivations for MedPAC's recommendations.

- We completed the most recent Five-Year Review of work RVUs, resulting in an increase in over 25 percent to the work RVUs for primary care services.
- We significantly revised the methodology for determining PE RVUs, resulting in more than a 5 percent increase for primary care services.
- We improved our processes for identifying potentially misvalued services by engaging in an ongoing review that includes screens for rapidly growing services and services with substantial shifts in site of service. We also identified approaches to address the issue of potentially misvalued services including reviewing services often billed together and the possibility of expanding the multiple procedure payment reduction (MPPR) to additional nonsurgical procedures and the update of high cost supplies.
- As discussed elsewhere in this proposed rule, we are proposing a number of improvements to the calculation and establishment of the work, PE, and malpractice RVUs that would result in overall payment increases to primary care specialties of between 6 percent and 8 percent in CY 2010. These changes include a 6 percent increase in the work RVUs for office visits as a result of our proposal regarding consultation services; our proposed use of more accurate specialty-specific survey data on physician practice costs; our proposal to revise the utilization rate assumption for certain equipment; and our proposed use of updated and expanded malpractice premium data in the calculation of the malpractice RVUs.

MedPAC has in the past also recommended the establishment of a group panel of experts separate from the AMA RUC to review RVUs. This original March 2006 recommendation was summarized in its March 2008 Report to Congress:

> ''We also recommended that CMS establish a group of experts, separate from the AMA RUC, to help the agency conduct these and other activities. This recommendation was intended not to supplant the AMA RUC but to augment it. To that end, the panel should include members who do not directly benefit from changes to Medicare's payment rates, such as experts in medical economics and technology diffusion and physicians who are employed by managed care organizations and academic medical centers.''

The idea of a group of experts separate from the AMA RUC, to help the agency improve the review of relative values raises a number of issues. We seek broad public input on the following questions and other aspects of such an approach:

- How could input from a group of experts best be incorporated into existing processes of rulemaking and agency receipt of AMA RUC recommendations?
- What specifically would be the roles of a group of experts (for example,

identify potentially misvalued services, provide recommendations on valuation of specified services, review AMA RUC recommendations selected by the Secretary, *etc.*)?

• What should be the composition of a group of experts? How could such a group provide expertise on services that clinician group members do not furnish?

• How would such a group relate to the AMA RUC and existing Secretarial advisory panels such as the Practicing Physician Advisory Committee?

Also of interest are comments on the resources required to establish and maintain such a group. As MedPAC noted in its March 2006 Report with respect to the group of experts ''we recognize that these recommendations will increase demands on CMS and urge the Congress to provide the agency with the financial resources and administrative flexibility needed to undertake them.''

We welcome comments on these topics, as well as others of interest to the stakeholder community. We will consider these comments as we consider the establishment of a group of experts to assist us in our ongoing reviews of the PFS RVUs.

G. Issues Related to the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)

This section addresses certain provisions of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110–275). We are proposing to revise our policies and regulations as described below in order to conform them to the statutory amendments.

1. Section 102: Elimination of Discriminatory Copayment Rates for Medicare Outpatient Psychiatric Services

Prior to the enactment of the MIPPA, section 1833(c) of the Act provided that for expenses incurred in any calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital, only 62½ percent of such expenses are considered to be incurred under Medicare Part B when determining the amount of payment and application of the Part B deductible in any calendar year. This provision is known as the outpatient mental health treatment limitation (the limitation), and has resulted in Medicare paying only 50 percent of the approved amount for outpatient mental health treatment, rather than the 80 percent that is paid for most other outpatient services.

Section 102 of the MIPPA amends the statute to phase out the limitation on recognition of expenses incurred for outpatient mental health treatment, which will result in an increase in the Medicare Part B payment for outpatient mental health services to 80 percent by CY 2014. When this section is fully implemented in 2014, Medicare will pay for outpatient mental health services at the same level as other Part B services. For CY 2010, section 102 of the MIPPA provides that Medicare will recognize 68¾ percent of expenses incurred for outpatient mental health treatment, which translates to a payment of 55 percent of the Medicare-approved amount. Section 102 of the MIPPA specifies that the phase out of the limitation will be implemented as shown in Table 9 (provided that the patient has satisfied his or her deductible).

TABLE 9—IMPLEMENTATION OF SECTION 102 OF THE MIPPA

Calendar year	Recognized incurred expenses (in percent)	Patient pays (in percent)	Medicare pays (in percent)
CY 2009 and prior calendar years	62.50	50	50
CY 2010 and CY 2011	68.75	45	55
CY 2012	75.00	40	60
CY 2013	81.25	35	65
CY 2014	100.00	20	80

At present, § 410.155(c) of the regulations includes examples to illustrate application of the current limitation. We are proposing to remove these examples from our regulations and, instead, to provide examples in this proposed rule, in our manual, and under provider education materials as needed. The following examples illustrate the application of the limitation in various circumstances as it is gradually reduced under section 102 of the MIPPA. We note that although we have used the CY 2009 Part B deductible of $135 for purposes of the examples below, the actual deductible amount for CY 2010 and future years will be subject to change.

Example #1: In 2010, a clinical psychologist submits a claim for $200 for outpatient treatment of a patient's mental disorder. The Medicare-approved amount is $180. Since clinical psychologists must accept assignment, the patient is not liable for the $20 in excess charges. The patient previously satisfied the $135 annual Part B deductible. The limitation reduces the amount of incurred expenses to 68¾ percent of the approved amount. Medicare pays 80 percent of the remaining incurred expenses. The Medicare payment and patient liability are computed as shown in Table 10.

TABLE 10—EXAMPLE #1—CY 2010

1. Actual charges	$200.00
2. Medicare-approved amount	180.00
3. Medicare incurred expenses (0.6875 × line 2)*	123.75
4. Unmet deductible	0.00
5. Remainder after subtracting deductible (line 3 minus line 4)	123.75
6. Medicare payment (0.80 × line 5)	99.00
7. Patient liability (line 2 minus line 6)	81.00

*The recognized incurred expenses for 2010 are 68¾ percent.

Example #2: In 2012, a clinical social worker submits a claim for $135 for outpatient treatment of a patient's mental disorder. The Medicare-approved amount is $120. Since clinical social workers must accept assignment, the patient is not liable for the $15 in excess charges. The limitation reduces the amount of incurred expenses to 75 percent of the approved amount. The patient previously satisfied $70 of the $135 annual Part B deductible, leaving $65 unmet (*see* Table 11).

TABLE 11—EXAMPLE #2—CY 2012

1. Actual charges	$135.00
2. Medicare-approved amount	120.00
3. Medicare incurred expenses (0.75 × line 2)*	90.00
4. Unmet deductible	65.00
5. Remainder after subtracting deductible (line 3 minus line 4)	25.00
6. Medicare payment (0.80 × line 5)	20.00
7. Patient liability (line 2 minus line 6)	100.00

*The recognized incurred expenses for CY 2012 are 75 percent.

Example #3: In CY 2013, a physician who does not accept assignment submits a claim for $780 for services in connection with the treatment of a mental disorder that did not require inpatient hospitalization. The Medicare-approved amount is $750. Because the physician does not accept assignment, the patient is liable for the $30 in excess charges. The patient has not satisfied any of the $135 Part B annual deductible (*see* Table 12).

TABLE 12—EXAMPLE #3—CY 2013

1. Actual charges	$780.00
2. Medicare-approved amount	750.00
3. Medicare incurred expenses (0.8125 × line 2)*	609.38
4. Unmet deductible	135.00
5. Remainder after subtracting deductible (line 3 minus line 4)	474.38
6. Medicare payment (0.80 × line 5)	379.50
7. Patient liability (line 1 minus line 6)	400.50

*The recognized incurred expenses for CY 2013 are 81¼ percent.

Example #4: A patient's Part B expenses during CY 2014 are for a physician's services in connection with the treatment of a mental disorder that initially required inpatient hospitalization, with subsequent physician services furnished on an outpatient basis. The patient has not satisfied any of the $135 Part B deductible. The physician accepts assignment and submits a claim for $780. The Medicare-approved amount is $750. Since the limitation will be completely phased out as of January 1, 2014, the entire $750 Medicare-approved amount is recognized as the total incurred expenses because such expenses are no longer reduced. Also, there is no longer any distinction between mental health services the patient receives as an inpatient or outpatient (*see* Table 13).

TABLE 13—EXAMPLE #4—CY 2014

1. Actual charges	$780.00
2. Medicare-approved amount	750.00
3. Medicare incurred expenses (1.00 × line 2)*	750.00
4. Unmet deductible	135.00
5. Remainder after subtracting deductible (line 3 minus line 4)	615.00
6. Medicare payment (0.80 × line 5)	492.00
7. Beneficiary liability (line 2 minus line 6)	258.00

*The recognized incurred expenses for CY 2014 are 100 percent.

Section 102 of the MIPPA did not make any other changes to the outpatient mental health treatment limitation. Therefore, other aspects of the limitation will remain unchanged during the transition period between CYs 2010 and 2014. The limitation will continue to be applied as it has been in accordance with our regulation at § 410.155(b) which specifies that the limitation applies to outpatient treatment of a mental, psychoneurotic, or personality disorder, identified under the International Classification of Diseases (ICD) diagnosis code range 290–319. We use the place of service code, and the procedure code to identify services to which the limitation applies.

Additionally, we are proposing to make technical corrections to § 410.155(b)(2) in order to update and clarify the services to which the limitation does not apply. Our proposed technical changes are as follows:

- Under § 410.155(b)(2)(ii), revise the regulation to specify the HCPCS code, M0064 (or any successor code), that represents the statutory exception to the limitation for brief office visits for the sole purpose of monitoring or changing drug prescriptions used in mental health treatment.
- At § 410.155(b)(2)(iv), we are proposing to revise the regulation to add neuropsychological tests and diagnostic psychological tests to the examples of diagnostic services that are not subject to the limitation when performed to establish a diagnosis.
- Under § 410.155(b)(2)(v), we are proposing to revise the regulation to specify the CPT code 90862 (or any successor code) that represents pharmacologic management services to which the limitation does not apply when furnished to treat a patient who is diagnosed with Alzheimer's disease or a related disorder.

Finally, we are proposing to add a new paragraph (c) to § 410.155 that provides a basic formula for computing the limitation during the phase-out period from CY 2010 through CY 2013, as well as after the limitation is fully removed from CY 2014 onward.

2. Section 131: Physician Payment, Efficiency, and Quality Improvements—Physician Quality Reporting Initiative (PQRI)

a. Program Background and Statutory Authority

The Physician Quality Reporting Initiative (PQRI) is a voluntary reporting program that provides an incentive payment to eligible professionals who satisfactorily report data on quality measures for covered professional services during a specified reporting period. Under section 1848(k)(3)(B) of the Act, the term ''eligible professional'' means any of the following: (1) A physician; (2) A practitioner described in section 1842(b)(18)(C); (3) A physical or occupational therapist or a qualified speech-language pathologist; (4) A qualified audiologist. The PQRI was first implemented in 2007 as a result of section 101 of Division B of the Tax Relief and Health Care Act of 2006—the Medicare Improvements and Extension Act of 2006 (Pub. L. 109–432) (MIEA–TRHCA), which was enacted on December 20, 2006. The PQRI was extended and further enhanced as a result of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. 110–173) (MMSEA), which was enacted on December 29, 2007, and the MIPPA, which was enacted on July 15, 2008. Changes to the PQRI as a result of these laws, as well as information about the PQRI in 2007, 2008, and 2009 are discussed in detail in the CY 2008 PFS proposed rule (72 FR 38196 through 38204), CY 2008 PFS final rule with comment period (72 FR 66336 through 66353), CY 2009 PFS proposed rule (73 FR 38558 through 38575), and CY 2009 PFS final rule with comment period (73 FR 69817 through 69847). In addition, detailed information about the PQRI is available on the CMS Web site at *http://www.cms.hhs.gov/PQRI*.

b. Incentive Payments for the 2010 PQRI

For 2010, section 1848(m)(1)(B) of the Act authorizes the Secretary to provide an incentive payment equal to 2.0 percent of the estimated total allowed charges (based on claims submitted not later than 2 months after the end of the reporting period) for all covered professional services furnished during the reporting period for 2010. Although PQRI incentive payments are only authorized through 2010 under section 1848(m)(1)(A) of the Act, section 1848(k)(2)(C) of the Act provides for the use of consensus-based quality measures for the PQRI for 2010 and subsequent years.

The PQRI incentive payment amount is calculated using estimated allowed charges for all covered professional services furnished under the PFS, not just those charges associated with the reported quality measures. ''Allowed charges'' refers to total charges, including the beneficiary deductible and coinsurance, and is not limited to the 80 percent paid by Medicare or the portion covered by Medicare where Medicare is secondary payer. Amounts billed above the PFS amounts for assigned and non-assigned claims will not be included in the calculation of the incentive payment amount. In addition, since, by definition under section 1848(k)(3)(A)) of the Act, ''covered professional services'' are limited to services for which payment is made under, or is based on, the PFS and which are furnished by an eligible professional, other Part B services and items that may be billed by eligible professionals but are not paid under or based upon the Medicare Part B PFS are not included in the calculation of the incentive payment amount.

Under section 1848(m)(6)(C) of the Act, the ''reporting period'' for the 2008 through 2011 PQRI is defined to be the entire year, but the Secretary is authorized to revise the reporting period for years after 2009 if the Secretary determines such ''revision is appropriate, produces valid results on measures reported, and is consistent with the goals of maximizing scientific validity and reducing administrative burden.''

We are also required by section 1848(m)(5)(F) of the Act to establish alternative criteria for satisfactorily reporting and alternative reporting periods for registry-based reporting and for reporting measures groups. Therefore, eligible professionals who meet the proposed alternative criteria for satisfactorily reporting for registry-based reporting and for reporting measures groups for the proposed 2010 alternative reporting periods for registry-based reporting and for reporting measures groups would also be eligible to earn an incentive payment equal to 2.0 percent of the estimated total Medicare Part B PFS allowed charges for all covered professional services furnished by the eligible professional during the proposed alternative reporting periods for 2010 PQRI registry-based reporting or for reporting measures groups.

The proposed PQRI reporting options for an individual eligible professional seeking to qualify for a 2010 PQRI incentive payment (that is, the proposed PQRI reporting mechanisms, proposed reporting periods, and proposed criteria for satisfactory reporting, including the proposed alternative reporting periods and alternative criteria for satisfactorily reporting for registry-based reporting and for reporting measures groups) are addressed in sections II.G.2.c. through II.G.2.f. of this proposed rule. The proposed 2010 PQRI quality measures and proposed 2010 PQRI measures groups are discussed in section II.G.2.i. of this proposed rule.

Prior to 2010, the PQRI was an incentive program in which determination of whether an eligible professional satisfactorily reported quality data was made at the individual professional level, based on the National Provider Identifier (NPI). Although the incentive payments were made to the practice(s) represented by the Tax Identification Number (TIN) to which payments are made for the individual professional's services, there were no incentive payments made to the group practice based on a determination that the group practice, as a whole, satisfactorily reported PQRI quality measures data. To the extent individuals (based on the individuals' NPIs) satisfactorily reported data on PQRI quality measures that were associated with more than one practice or TIN, the determination of whether an eligible professional satisfactorily reported PQRI quality measures data was made for each unique TIN/NPI combination. Therefore, the incentive payment amount was calculated for each unique TIN/NPI combination and payment was made to the holder of the applicable TIN.

However, section 1848(m)(3)(C)(i) of the Act requires that by January 1, 2010, the Secretary establish and have in place a process under which eligible professionals in a group practice (as defined by the Secretary) shall be treated as satisfactorily submitting data on quality measures for the PQRI for covered professional services for a reporting period, if, in lieu of reporting measures under subsection (k)(2)(C), the group practice reports measures determined appropriate by the Secretary, such as measures that target high-cost chronic conditions and preventive care, in a form and manner, and at a time, specified by the Secretary. Therefore, beginning with the 2010 PQRI, group practices who satisfactorily submit data on quality measures also would be eligible to earn an incentive payment equal to 2.0 percent of the

estimated total allowed charges for all covered professional services furnished by the group practice during the applicable reporting period. As required by section 1848(m)(3)(C)(iii) of the Act, payments to a group practice by reason of the process described above shall be in lieu of the PQRI incentive payments that would otherwise be made to eligible professionals in the group practice for satisfactorily submitting data on quality measures. Therefore, an individual eligible professional who is participating in the group practice reporting option as a member of a group practice would not be able to separately earn a PQRI incentive payment as an individual eligible professional.

The process proposed to be used to determine whether a group practice satisfactorily submits data on quality measures for the 2010 PQRI is described in section II.G.2.g. of this proposed rule. The proposed measures on which a group practice would need to report in order to be treated as satisfactorily submitting data on quality measures for the 2010 PQRI are discussed in section II.G.2.j. of this proposed rule.

c. Proposed 2010 Reporting Periods for Individual Eligible Professionals

As we indicated above, section 1848(m)(6)(C) of the Act defines ''reporting period'' for 2010 to be the entire year. Section 1848(m)(6)(C)(ii) of the Act, however, authorizes the Secretary to revise the reporting period for years after 2009 if the Secretary determines such revision is appropriate, produces valid results on measures reported, and is consistent with the goals of maximizing scientific validity and reducing administrative burden. To be consistent with section 1848(m)(6)(C) of the Act and with prior years, we propose the 2010 PQRI reporting period for the reporting of individual PQRI quality measures through claims or a qualified electronic health record (EHR) (*see* section II.G.2.d. of this proposed rule for discussion of proposed 2010 PQRI reporting mechanisms) will be the entire year (that is, January 1, 2010 through December 31, 2010).

We also considered exercising our authority to revise the reporting period for claims-based reporting of individual measures by proposing to add an alternative reporting period beginning July 1, 2010 for claims-based reporting of individual measures. Doing so would make the reporting periods for claims-based reporting of individual measures consistent with the alternative reporting periods for reporting measures groups and for registry-based reporting that have been in place since the 2008 PQRI. This would allow an eligible professional to earn a PQRI incentive payment equal to 2.0 percent of his or her estimated allowed charges for covered professional services furnished for the last half of 2010 if he or she satisfactorily reports data on individual PQRI quality measures through claims during the last half of 2010. We received input from a few stakeholders in support of a partial year reporting period for claims-based reporting of individual measures to give more eligible professionals the opportunity to begin reporting later in the year. Other stakeholders recommended that we offer the same reporting periods for all reporting mechanisms. We agree that having the same reporting periods for all reporting mechanisms may be less complex. We also agree that the addition of a 6-month reporting period may facilitate participation in PQRI for certain eligible professionals. However, we do not believe that making a 6-month reporting period available would serve to enhance the validity of results on measures reported or to maximize scientific validity as required under section 1848(m)(6)(C)(ii) of the Act. In addition, given our desire to transition from the use of the claims-based reporting mechanism as the primary reporting mechanism for clinical quality measures for PQRI after 2010 to rely more heavily on registry-based reporting (*see* section II.G.2.d. of this proposed rule for further discussion), we do not believe it appropriate to add a new 6-month reporting period for claims-based reporting of individual measures. Given the fact that we seek to lessen reliance on the claims-based reporting mechanism for the PQRI after 2010, we believe the cost of adding a 6-month reporting period for claims-based reporting of individual measures outweighs any added flexibility that eligible professionals may receive in the short-term.

Nevertheless, we invite comments on the decision to not propose a 6-month reporting period for claims-based reporting of individual PQRI quality measures.

In addition, section 1848(m)(5)(F) of the Act requires, for 2008 and subsequent years, the Secretary to establish alternative reporting periods for reporting groups of measures and for registry-based reporting. To satisfy the requirements of section 1848(m)(5)(F) of the Act and to maintain program stability, we propose to retain the 2 alternative reporting periods from the 2008 and 2009 PQRI for reporting measures groups and for registry-based reporting: (1) The entire year; and (2) a 6-month reporting period beginning July 1. Therefore, for 2010, the proposed alternative reporting periods for reporting measures groups and for registry-based reporting are: (1) January 1, 2010 through December 31, 2010; and (2) July 1, 2010 through December 31, 2010. We note that the 6-month reporting period, beginning July 1, 2010, is proposed to be available for reporting on measures groups and for reporting using the registry-based reporting mechanism only. For an eligible professional who satisfactorily reports measures groups or through the registry-based reporting mechanism for the 6-month reporting period, the eligible professional would qualify to earn a PQRI incentive payment equal to 2.0 percent of his or her total estimated allowed charges for covered professional services furnished between July 1, 2010 and December 31, 2010 only. The incentive payment would not be calculated based on the eligible professional's charges for covered professional services for the entire year.

d. Proposed 2010 PQRI Reporting Mechanisms for Individual Eligible Professionals

When the PQRI was first implemented in 2007, there was only 1 reporting mechanism available to submit data on PQRI quality measures. For the 2007 PQRI, the only way that eligible professionals could submit data on PQRI quality measures was by reporting the appropriate quality data codes on their Medicare Part B claims (claims-based reporting). For the 2008 PQRI, we added a second reporting mechanism as required by section 1848(k)(4) of the Act, so that eligible professionals could submit data on PQRI quality measures to a qualified PQRI registry and request the registry to submit PQRI quality measures results and numerator and denominator data on the 2008 PQRI quality measures or measures groups on their behalf (registry-based reporting). For the 2009 PQRI, we retained the 2 reporting mechanisms used in the 2008 PQRI (that is, claims-based reporting and registry-based reporting) for reporting individual PQRI quality measures and for reporting measures groups.

To promote the adoption of EHRs, we also conducted limited testing of a third reporting mechanism for the 2008 PQRI, which was the submission of clinical quality data extracted from an EHR, or the EHR-based reporting mechanism. No incentive payment was available to those eligible professionals who participated in testing the EHR-based reporting mechanism. In the CY 2009 PFS proposed rule (73 FR 38564 through 38565), we described our plans to test the submission of clinical quality

data extracted from qualified EHR products for five 2008 PQRI measures and proposed to accept PQRI data from EHRs and to pay PQRI incentive payments based on that submission for a limited subset of the proposed 2009 PQRI quality measures. However, as described in the CY 2009 PFS final rule with comment period (73 FR 69830), we did not finalize our proposal to allow eligible professionals to submit clinical quality data extracted from EHRs for purposes of receiving a PQRI incentive payment for 2009. Since the 2008 EHR testing process was not complete at the time of publication of the CY 2009 PFS final rule, we instead opted to continue to test the submission of clinical quality data extracted from EHRs in 2009 and provide no incentive payment to those eligible professionals participating in testing the EHR-based reporting mechanism in 2009.

For the 2010 PQRI, we are proposing to retain the claims-based reporting mechanism and the registry-based reporting mechanism. In addition, we are again proposing for the 2010 PQRI to accept PQRI quality measures data extracted from a qualified EHR product for a limited subset of the proposed 2010 PQRI quality measures, as identified in Table 20, contingent upon the successful completion of our 2009 EHR data submission testing process and a determination based on that testing process that accepting data from EHRs on quality measures for the 2010 PQRI is practical and feasible. We will make the determination as to whether accepting data from EHRs on quality measures is practical and feasible for the 2010 PQRI prior to publication of the CY 2010 PFS final rule with comment period. We will indicate in the CY 2010 PFS final rule with comment period whether we intend to finalize this proposal. If we finalize this proposal, then, unlike in prior years, an eligible professional would be able to earn a PQRI incentive payment through the EHR-based reporting mechanism in 2010.

We seek to offer more reporting mechanisms because we recognize that 1 mode of quality reporting does not suit all practices and our experience with the registry-based reporting mechanism thus far has been favorable. While the availability of multiple reporting mechanisms should increase opportunities for eligible professionals to satisfactorily report quality data for the PQRI, we also recognize that there are a number of limitations associated with claims-based reporting. On one hand, claims submission is available to nearly all eligible professionals. On the other hand, submission of quality data on claims has certain drawbacks since the claims processing system was developed for billing purposes and not for the submission of quality data. As we noted in the CY 2009 PFS final rule with comment period (73 FR 69833), for example, measures with complex specifications, such as those that require multiple diagnosis codes are not as conducive to claims-based reporting and may be associated with a greater number of invalidly reported quality data codes. Similarly, when multiple measures share the same codes it may be difficult to determine which measure(s) the eligible professional intended to report through claims.

We believe that EHR-based reporting is a viable option for overcoming the limitations associated with claims-based reporting of quality measures. Therefore, we propose to add an EHR-based reporting mechanism for the 2010 PQRI in order to promote the adoption and use of EHRs and to provide both eligible professionals and CMS experience on EHR-based quality reporting.

Furthermore, on February 17, 2009, the President signed into law the American Recovery and Reinvestment Act (the Recovery Act) (Pub. L. 111–5). Section 4101(a) of the Health Information Technology for Economic and Clinical Health (HITECH) Act (Title IV of Division B of the Recovery Act, together with Title XIII of Division A of the Recovery Act), which amends section 1848 of the Act to add new subsection (o), authorizes incentive payments under Medicare for certain eligible professionals who are ''meaningful EHR users'' beginning in 2011. However, the provisions in this proposed rule do not implement any HITECH Act statutory provisions. While our efforts to encourage the adoption and use of EHRs through testing EHR-based data submission in the 2008 and 2009 PQRI and our proposal to add an EHR-based reporting mechanism for the purpose of receiving a PQRI incentive payment for the 2010 PQRI could potentially provide invaluable experience and serve as a foundation for establishing the capacity for eligible professionals to send, and for CMS to receive, data on quality measures via EHRs, the provisions of the HITECH Act will be implemented in future notice and comment rulemaking.

In summary, we propose that for 2010, an eligible professional may choose to report data on PQRI quality measures through claims, to a qualified registry (for the qualification requirements for registries, see section II.G.2.i.(4) of this proposed rule), or through a qualified EHR product (for the qualification requirements for EHR vendors and their products, see section II.G.2.i.(5) of this proposed rule). Depending on which PQRI individual quality measures or measures groups an eligible professional selects, however, one or more of the proposed reporting mechanisms may not be available for reporting a particular 2010 PQRI individual quality measure or measures group. The proposed 2010 reporting mechanisms through which each proposed 2010 PQRI individual quality measure and measures group could be reported is identified in Tables 14 through 15. We invite comments on the proposed reporting mechanisms for the 2010 PQRI, including our proposal to add an EHR-based reporting mechanism to the 2010 PQRI, contingent upon the successful completion of our 2009 EHR data submission testing process and a determination that accepting data from EHRs on quality measures for the 2010 PQRI is practical and feasible.

While we propose to retain the claims-based reporting mechanism for 2010, we note that we are considering significantly limiting the claims-based mechanism of reporting clinical quality measures for the PQRI after 2010. This would be contingent upon there being an adequate number and variety of registries available and/or EHR reporting options. Potentially, we would retain claims-based reporting in years after 2010 principally for the reporting of structural measures, such as Measure #124 Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR), and circumstances where claims-based reporting is the only available mechanism for certain categories of eligible professionals to report on PQRI quality measures.

Reducing our reliance on the claims-based reporting mechanism after 2010 will allow us and eligible professionals to devote available resources to maximizing the potential of registries and EHRs for quality measurement reporting. Both mechanisms hold the promise of more sophisticated and timely reporting on clinical quality measures. Clinical data registries allow the collection of more detailed data, including outcomes, without the necessity of a single submission contemporaneously with claims billing, which overcomes some of the limitations of the claims-based reporting mechanism. Registries can also provide feedback and quality improvement information based on reported data. Finally, clinical data registries can also receive data from EHRs, and therefore, serve as an alternative means to reporting clinical quality data extracted

from an EHR. As we continue to qualify additional registries, we believe that there will be a sufficient number of qualified PQRI registries by 2011 to make it possible to reduce or even discontinue the claims-based reporting mechanism for most measures after 2010. We invite comments on our intent to lessen our reliance on the claims-based reporting mechanism for the PQRI beyond 2010.

Regardless of the reporting mechanism chosen by an eligible professional, there is no requirement for the eligible professional to sign up or register to participate in the PQRI. However, there may be some requirements for participation through a specific reporting mechanism that are unique to that particular reporting mechanism. In addition to the criteria for satisfactory reporting of individual measures and measures groups described in sections II.G.2.e. and II.G.2.f., respectively, of this proposed rule, eligible professionals must ensure that they meet all requirements for their chosen reporting mechanism.

(1) Requirements for Individual Eligible Professionals Who Choose the Claims-Based Reporting Mechanism

For eligible professionals who choose to participate in the PQRI by submitting data on individual quality measures or measures groups through the claims-based reporting mechanism, the only requirement associated with claims-based reporting that we are proposing apart from the proposed criteria for satisfactory reporting of individual measures and measures described below in sections II.G.2.e. and II.G.2.f., respectively, of this proposed rule, is the submission of the appropriate PQRI quality data codes on the professionals' Medicare Part B claims. An eligible professional would be permitted to submit the quality data codes for the eligible professional's selected individual PQRI quality measures or measures group at any time during the 2010 reporting period. Please note, however, that as required by section 1848(m)(1)(A) of the Act, all claims for services furnished between January 1, 2010 and December 31, 2010 must be processed by no later than February 28, 2011 to be included in the 2010 PQRI analysis.

(2) Requirements for Individual Eligible Professionals Who Choose the Registry-Based Reporting Mechanism

In order to report quality measures results and numerator and denominator data on the 2010 PQRI individual quality measures or measures group through a qualified clinical registry, we propose that eligible professionals would need to enter into and maintain an appropriate legal arrangement with a qualified 2010 PQRI registry. Such arrangements would provide for the registry's receipt of patient-specific data from the eligible professional and the registry's disclosure of quality measures results and numerator and denominator data on PQRI quality measures or measures groups on behalf of the eligible professional to CMS. Thus, the registry would act as a Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191) (HIPAA) Business Associate and agent of the eligible professional. Such agents are referred to as ''data submission vendors.'' The ''data submission vendors'' would have the requisite legal authority to provide clinical quality measures results and numerator and denominator data on individual quality measures or measures groups on behalf of the eligible professional for the PQRI. The registry, acting as a data submission vendor, would submit registry-derived measures information to the CMS designated database for the PQRI, using a CMS-specified record layout. The record layout will be provided to the registry by CMS.

To maintain compliance with applicable statutes and regulations, our program and its data system must maintain compliance with the HIPAA requirements for requesting, processing, storing, and transmitting data. Eligible professionals that conduct HIPAA covered transactions also must maintain compliance with the HIPAA requirements.

Eligible professionals choosing to participate in PQRI by submitting quality measures results and numerator and denominator data on PQRI individual quality measures or measures groups through the registry-based reporting mechanism for 2010 would need to select a qualified PQRI registry and submit information on PQRI individual quality measures or measures groups to the selected registry in the form and manner and by the deadline specified by the registry.

The process and requirements that we propose to use to determine whether a registry is qualified to submit quality measures results and numerator and denominator data on PQRI quality measures or measures groups on an eligible professional's behalf in 2010 are described in section II.G.2.d. of this proposed rule. We will post on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov* a list of qualified registries for the 2010 PQRI, including the registry name, contact information, and the 2010 measure(s) and/or measures group(s) for which the registry is qualified and intends to report. We propose to post the names of 2010 PQRI qualified registries in 2 phases. In either event, even though a registry is listed as ''qualified,'' we cannot guarantee or assume responsibility for the registry's successful submission of PQRI quality measures results and numerator and denominate data on PQRI quality measures or measures groups on behalf of eligible professionals.

In the first phase, we anticipate that by December 31, 2009, we will be able to, at minimum, post a list of those registries qualified for the 2010 PQRI based on: (1) Being a qualified registry for the 2008 and 2009 PQRI that successfully submitted 2008 PQRI quality measures results and numerator and denominator data on the quality measures; (2) having received a letter indicating their continued interest in being a PQRI registry for 2010; and (3) the registry's compliance with the 2010 PQRI registry requirements. By posting this first list of qualified registries for the 2010 PQRI, we seek to make available the names of registries that can be qualified at the start of the 2010 reporting period. We do this to accommodate requests we have received from eligible professionals who wish to avoid claims-based reporting pending knowing whether a particular registry is qualified for the 2010 PQRI.

In the second phase, we anticipate to complete posting of the list of qualified 2010 registries as soon as we have completed vetting the registries interested in participating in the 2010 PQRI and identified the qualified registries for the 2010 PQRI, which we anticipate will be completed by no later than Summer 2010. An eligible professional's ability to report PQRI quality measures results and numerator and denominator data on PQRI quality measures or measures groups using the registry-based reporting mechanism should not be impacted by the complete list of qualified registries for the 2010 PQRI being made available after the start of the reporting period. First, registries will not begin submitting eligible professionals' PQRI quality measures results and numerator and denominator data on the quality measures or measures groups to CMS until 2011. Second, if an eligible professional decides that he or she is no longer interested in submitting quality measures results and numerator and denominator data on PQRI individual quality measures or measures group through the registry-based reporting mechanism after the complete list of qualified registries becomes available, this does not preclude the eligible

professional from attempting to meet the criteria for satisfactory reporting through another 2010 PQRI reporting mechanism.

In addition to meeting the above proposed requirements specific to registry-based reporting, eligible professionals who choose to participate in PQRI through the registry-based reporting mechanism would need to meet the relevant criteria proposed for satisfactory reporting of individual measures or measures groups that all eligible professionals must meet in order to qualify to earn a 2010 PQRI incentive payment. The criteria for satisfactory reporting of individual measures and measures groups are described in sections II.G.2.e. and II.G.2.f., respectively, of this proposed rule.

(3) Requirements for Individual Eligible Professionals Who Choose the EHR-Based Reporting Mechanism

For eligible professionals who choose to participate in the 2010 PQRI by submitting data on individual quality measures through the EHR-based reporting mechanism, the only proposed requirements associated with EHR-based reporting other than meeting the criteria for satisfactory reporting of individual measures described in section II.G.2.e. of this proposed rule are to: (1) Select a qualified EHR product and (2) submit clinical quality data extracted from the EHR to a CMS clinical data warehouse. Provided that our 2009 EHR data submission testing process is successful, we propose to begin accepting submission of clinical quality data extracted from ''qualified'' EHRs on January 1, 2010, or as soon thereafter as is technically feasible. We propose that eligible professionals will have until March 31, 2011 to complete data submission through qualified EHRs for services furnished during the 2010 PQRI reporting period. The process that was used to determine whether an EHR vendor and its EHR product(s) are qualified to submit clinical quality data extracted from EHRs for the 2010 PQRI is described in section II.G.2.d.5. of this proposed rule.

The specifications for the electronic transmission of the proposed 2010 PQRI measures identified in Table 20 (section II.G.2.i.(4) of this proposed rule) as being under consideration for EHR-based reporting in 2010 will be posted on a public Web site when available. We will announce the availability and exact location of these specifications through familiar CMS communications channels, including the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI*. The posting of specifications for the electronic transmission of any particular measure prior to publication of the final rule does not signify that the measure will necessarily be selected for the 2010 PQRI measure set, nor that EHR-based reporting will be accepted for that measure even if it may otherwise be included in the 2010 PQRI. However, by posting the specifications for electronic transmission of these measures, we seek to allow sufficient time for EHR vendors to adapt their products to support EHR-based capture and submission of data for these measures prior to the start of any 2010 PQRI reporting periods.

We do not propose any option to report measures groups through EHR-based reporting on services furnished during 2010. Because EHR-based reporting to CMS of data on quality measures would be new to PQRI for 2010, we propose to make available only the criteria applicable to reporting of individual PQRI measures.

We cannot assume responsibility for the successful submission of data from eligible professionals' EHRs. Any eligible professional who chooses to submit PQRI data extracted from an EHR should contact the EHR product's vendor to determine if the product is qualified and has been updated to facilitate PQRI quality measures data submission. Such professionals also should begin attempting submission promptly after we announce that the clinical data warehouse is ready to accept 2010 PQRI quality measures data through the EHR mechanism in order to assure the professional has a reasonable period of time to work with his or her EHR and/or its vendor to correct any problems that may complicate or preclude successful quality measures data submission through that EHR. As we indicated above, data submission for the 2010 PQRI would need to be completed by March 31, 2011.

(4) Qualification Requirements for Registries

In order to be ''qualified'' to submit quality measures results and numerator and denominator data on PQRI quality measures and measures groups on behalf of eligible professionals pursuing incentive payment for the 2008 and 2009 PQRI, we required registries to complete a self-nomination process and to meet certain technical and other requirements. For the 2009 PQRI, registries that were ''qualified'' for 2008 did not need to be ''re-qualified'' for 2009 unless they were unsuccessful at submitting 2008 PQRI data (that is, failed to submit 2008 PQRI data per the 2008 PQRI registry requirements). Registries that were ''qualified'' for 2008 and wished to continue to participate in 2009 were only required to communicate their desire to continue participation for 2009 by submitting a letter to CMS indicating their continued interest in being a PQRI registry for 2009 and their compliance with the 2009 PQRI registry requirements by March 31, 2009.

For the 2010 PQRI, we are again proposing to require a self-nomination process for registries wishing to submit 2010 PQRI quality measures or measures groups on behalf of eligible professionals for services furnished during the applicable reporting periods in 2010. Similar to the 2008 and 2009 PQRI registry self-nomination process, the proposed registry self-nomination process for the 2010 PQRI would be based on a registry meeting specific technical and other requirements.

In order to be consistent with the registry requirements from prior program years, we propose that the 2010 registry requirements be substantially the same as for 2008 and 2009. Specifically, to be considered a qualified registry for purposes of submitting individual quality measures and measures groups on behalf of eligible professionals who choose to report using this reporting mechanism under the 2010 PQRI, we propose that a registry would need to:

- Be in existence as of January 1, 2009.
- Be able to collect all needed data elements and calculate results for at least 3 measures in the 2010 PQRI program (according to the posted 2010 PQRI Measure Specifications).
- Be able to calculate and submit measure-level reporting rates by TIN/NPI;
- Be able to calculate and submit, by TIN/NPI, a performance rate (that is, the percentage of a defined population who receive a particular process of care or achieve a particular outcome) for each measure on which the TIN/NPI reports;
- Be able to separate out and report on Medicare Part B FFS patients;
- Provide the name of the registry;
- Provide the reporting period start date the registry will cover;
- Provide the reporting period end date the registry will cover;
- Provide the measure numbers for the PQRI quality measures on which the registry is reporting;
- Provide the measure title for the PQRI quality measures on which the registry is reporting;
- Report the number of eligible instances (reporting denominator);
- Report the number of instances of quality service performed (numerator);

- Report the number of performance exclusions;
- Report the number of reported instances, performance not met (eligible professional receives credit for reporting, not for performance);
- Be able to transmit this data in a CMS-approved XML format. We expect that this CMS-specified record layout will be substantially the same as for the 2008 and 2009 PQRI. This layout will be provided to registries in 2010;
- Comply with a CMS-specified secure method for data submission, such as submitting its data in an XML file through an Individuals Access to CMS Systems (IACS) user account;
- Submit an acceptable ''validation strategy'' to CMS by March 31, 2010. A validation strategy ascertains whether eligible professionals have submitted accurately and on at least the minimum number (80 percent) of their eligible patients, visits, procedures, or episodes for a given measure. Acceptable validation strategies often include such provisions as the registry being able to conduct random sampling of their participants' data, but may also be based on other credible means of verifying the accuracy of data content and completeness of reporting or adherence to a required sampling method;
- Enter into and maintain with its participating professionals an appropriate Business Associate agreement that provides for the registry's receipt of patient-specific data from the eligible professionals, as well as the registry's disclosure of quality measure results and numerator and denominator data on behalf of eligible professionals who wish to participate in the PQRI program;
- Obtain and keep on file signed documentation that each holder of an NPI whose data are submitted to the registry has authorized the registry to submit quality measures results and numerator and denominator data to CMS for the purpose of PQRI participation. This documentation must be obtained at the time the eligible professional signs up with the registry to submit PQRI quality measures data to the registry and must meet any applicable laws, regulations, and contractual business associate agreements;
- Provide CMS access (if requested) to review the Medicare beneficiary data on which 2010 PQRI registry-based submissions are founded;
- Provide the reporting option (reporting period and reporting criteria) that the eligible professional has satisfied or chosen; and
- Provide CMS a signed, written attestation statement via mail or e-mail which states that the quality measure results and numerator and denominator data provided to CMS are accurate and complete.

With respect to the submission of 2010 measure results and numerator and denominator data on measures groups, we propose to retain the following registry requirements from the 2009 PQRI:

- Indicate the reporting period chosen for each eligible professional who chooses to submit data on measures groups;
- Base reported information on measures groups only on patients to whom services were furnished during the 12-month reporting period of January through December 2010 or the 6-month reporting period of July 2010 through December 2010;
- Agree that the registry's data may be inspected by CMS under our oversight authority if non-Medicare patients are included in the patient sample;
- Be able to report data on all of the measures in a given measures group and on either 30 patients from January 1 through December 31, 2010 (note this patient sample must include some Medicare Part B FFS beneficiaries) or on 80 percent of applicable Medicare Part B FFS patients for each eligible professional (with a minimum of 15 patients during the January 1, 2010 through December 31, 2010 reporting period or a minimum of 8 patients during the July 1, 2010 through December 31, 2010 reporting period) (*see* criteria for satisfactory reporting of measures groups described in section II.G.2.f. of this proposed rule for further information); and
- Be able to report the number of Medicare FFS patients and the number of Medicare Advantage patients that are included in the patient sample for a given measures group.

In addition to the above requirements, we propose the following new requirements for registries for the 2010 PQRI:

- Registries must have at least 25 participants;
- Registries must provide at least 1 feedback report per year to participating eligible professionals;
- Registries must not be owned and managed by an individual locally-owned single-specialty group (in other words, single-specialty practices with only 1 practice location or solo practitioner practices would be prohibited from self-nominating to become a qualified PQRI registry);
- Registries must participate in ongoing 2010 PQRI mandatory support conference calls hosted by CMS (approximately 1 call per month);
- Registries must provide a flow and XML of a measure's calculation process for each measure type that the registry intends to calculate; and
- Registries must use PQRI measure specifications to calculate reporting or performance unless otherwise stated.

These proposed new requirements are intended to improve the registry-based reporting mechanism by taking advantage of some of the registries' existing quality improvement functions, maximizing the registry's ability to successfully submit eligible professionals' quality measure results and numerator and denominator data on PQRI individual quality measures or measures groups to CMS, and discouraging small physician offices or an individual eligible professional from self-nominating to become a qualified registry. We are concerned that an individual eligible professional or a small practice does not have the resources or capabilities to successfully submit quality measures results and numerator and denominator data on PQRI individual measures or measures groups through the registry data submission process.

We propose to post the final 2010 PQRI registry requirements, including the exact date by which registries that wish to qualify for 2010 must submit a self-nomination letter and instructions for submitting the self-nomination letter, on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI* by November 15, 2009. We anticipate that new registries that wish to self-nominate for 2010 will be required to do so by January 31, 2010.

Similar to the 2009 PQRI, we propose that registries that were ''qualified'' for 2009 and wish to continue to participate in 2010 would not need to be ''re-qualified'' for 2010 unless they are unsuccessful at submitting 2009 PQRI data (that is, fail to submit 2009 PQRI data per the 2009 PQRI registry requirements). We further propose that registries that were ''qualified'' for 2009, were successful in submitting 2009 PQRI data, and wish to continue to participate in 2010 would need to indicate their desire to continue participation for 2010 by submitting a letter to CMS indicating their continued interest in being a PQRI registry for 2010 and their compliance with the 2010 PQRI registry requirements by no later than October 31, 2009. Instructions regarding the procedures for submitting this letter will be provided to qualified 2009 PQRI registries on the 2009 PQRI registry support conference calls.

If a qualified 2009 PQRI registry fails to submit 2009 PQRI data per the 2009 PQRI registry requirements, we propose

the registry would be considered unsuccessful at submitting 2009 PQRI data and would need to go through the full self-nomination process again to participate in the 2010 PQRI. By March 31, 2010, registries that are unsuccessful submitting quality measures results and numerator and denominator data for 2009 would need to be able to meet the 2010 PQRI registry requirements and go through the full vetting process again.

Finally, as discussed further under section II.G.5.c.(1) of this proposed rule, we propose that the above registry requirements would apply not only for the purpose of a registry qualifying to report 2010 PQRI quality measure results and numerator and denominator data on PQRI individual quality measures or measures groups, but also for the purpose of a registry qualifying to submit the proposed electronic prescribing measure for the 2010 E-Prescribing Incentive Program.

(5) Qualification Requirements for EHR Vendors and Their Products

In the CY 2009 PFS final rule with comment period (73 FR 69830), we announced our intent to qualify EHR vendors and their specific products to submit quality data extracted from their EHR products to the CMS clinical quality data warehouse so that we may potentially begin to accept data via EHRs for purposes of satisfactorily reporting data on quality measures in future PQRI reporting. We stated that we anticipate posting on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI*, by December 31, 2008, a list of requirements that EHR vendors must be able to meet in order to self-nominate to have their product ''qualified'' to potentially be able to submit quality measures data for the 2010 PQRI to CMS. We also stated that qualifying EHR vendors ahead of actual data submission will facilitate the live data submission process.

On December 31, 2008, the ''Requirements for Electronic Health Record (EHR) Vendors to Participate in the 2009 PQRI EHR Testing Program,'' was posted on the Reporting page of the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI/20_Reporting.asp#TopOfPage*, which described the EHR vendor requirements and the EHR vendor self-nomination process.

The vendor's EHR system must be updated according to the Draft 2009 EHR specifications posted on the QualityNet Web site at *http://www.qualitynet.org* in order for an EHR vendor and its product to qualify to submit test information on 2009 PQRI measures, and for possible EHR data submission for future PQRI reporting years. In addition, the 2009 PQRI EHR test-vendors must meet the following requirements:

- Be able to collect and transmit all required data elements according to the 2009 EHR Specifications.
- Be able to separate out and report on Medicare Part B FFS patients only.
- Be able to include TIN/NPI information submitted with an eligible professional's quality data.
- Be able to transmit this data in the CMS-approved format.
- Comply with a secure method for data submission.
- Enter into and maintain with its participating professionals an appropriate legal arrangement that provides for the EHR vendor to receive patient-specific data from the eligible professional, as well as the EHR vendor's disclosure of protected health information on behalf of eligible professionals who wish to participate in the 2009 PQRI EHR test program.
- Obtain and keep on file signed documentation that each NPI whose data is submitted to the EHR vendor has authorized the EHR vendor to submit patient data to CMS for the purpose of PQRI testing. This documentation must meet the standards of applicable law, regulations, and contractual or business associate agreements.

As described in the ''Requirements for Electronic Health Record (EHR) Vendors to Participate in the 2009 PQRI EHR Testing Program,'' which is posted on the Reporting page of the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI/20_Reporting.asp#TopOfPage*, EHR vendors who wish to qualify to participate in the 2009 PQRI EHR test program were required to submit a self-nomination letter requesting inclusion in the 2009 EHR testing process by February 13, 2009. All nominees would then go through a vetting process. Those nominees passing this vetting process would be asked to submit test data (that is, mock-up data) or to submit live test data from some of their clients (users) with their permission. Vendors who successfully submit their test data would also need to be able to adapt their system to any changes in the measure specifications that may arise due to Healthcare Information Technology Standards Panel (HITSP) or Certification Commission for Healthcare Information Technology (CCHIT) adoption of quality measure data reporting criteria.

It is expected that the process for qualifying self-nominated EHR vendors may conclude in 2009. At the conclusion of this process, we propose that those EHR products that meet all of the EHR vendor requirements will be listed on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI* as a ''qualified'' EHR product (that is, the name of the vendor software product and the version that is qualified), which indicates that the product's users may submit quality data to CMS (either directly from their system or through the vendor—which is yet to be determined) for the 2010 PQRI, if and when, EHR submission is included in the 2010 PQRI as a PQRI reporting mechanism.

As discussed further under section II.G.5.c.(1) of this proposed rule, we propose that the above EHR vendor requirements would apply not only for the purpose of a vendor's EHR product being qualified for the purpose of the product's users being able to submit data extracted from the EHR for the 2010 PQRI, but also for the purpose of a vendor's EHR product being qualified for the purpose of the product's users being able to electronically submit data extracted from the EHR for the electronic prescribing measure for the 2010 E-Prescribing Incentive Program.

During 2010, we expect to use the self-nomination process described in the ''Requirements for Electronic Health Record (EHR) Vendors to Participate in the 2009 PQRI EHR Testing Program'' posted on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI/20_Reporting.asp#TopOfPage*, to qualify additional EHR vendors and their EHR products to submit quality data extracted from their EHR products to the CMS clinical quality data warehouse for program years after 2010. We anticipate that the requirements will be similar to those used to qualify EHR products for the 2009 PQRI EHR testing, but they may be modified based on the results of our 2009 EHR testing. At the conclusion of this process, sometime in late 2010, those EHR products that meet all of the EHR vendor requirements will be listed on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI* as a ''qualified'' EHR product, which indicates that the product's users may submit quality data to CMS (either directly from their system or through the vendor—which is yet to be determined) for the 2011 PQRI or subsequent years, if and when, EHR submission is included as a PQRI reporting mechanism for years after 2010.

e. Proposed Criteria for Satisfactory Reporting of Individual Quality Measures for Individual Eligible Professionals

Under section 1848(m)(3)(A) of the Act, the criteria for satisfactorily

submitting data on individual quality measures through claims-based reporting require the reporting of at least 3 applicable measures in at least 80 percent of the cases in which the measure is reportable. If fewer than 3 measures are applicable to the services of the professional, the professional may meet the criteria by reporting on all applicable measures (that is, 1 to 2 measures) for at least 80 percent of the cases where the measures are reportable. It is assumed that if an eligible professional submits quality data codes for a particular measure, the measure applies to the eligible professional.

In prior program years, when we were required, under section 1848(m)(5)(F) of the Act, to establish alternative criteria for satisfactorily reporting using the registry-based reporting mechanism, we decided that the criteria for registry-based reporting of individual measures should be consistent with the criteria for claims-based reporting of individual measures. Thus, we adopted the same criteria for satisfactory reporting of individual measures through registry-based reporting as the criteria for satisfactory reporting of individual measures through claims-based reporting except that an eligible professional could choose to report through the registry-based reporting mechanism only if there are at least 3 PQRI quality measures applicable to the services of the professional. For the 2008 or 2009 PQRI, eligible professionals could not satisfactorily report PQRI measures through the registry-based reporting mechanism by reporting on fewer than 3 measures.

For years after 2009, section 1848(m)(3)(D) of the Act authorizes the Secretary, in consultation with stakeholders and experts, to revise the criteria for satisfactorily reporting data on quality measures. Based on this authority and the input we have received from stakeholders via the invitation to submit suggestions for the 2010 PQRI reporting options posted on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI* in April 2009, we propose 3 criteria for satisfactory reporting of individual PQRI quality measures for 2010. In an effort to continue to be consistent with the criteria of satisfactory reporting used in prior PQRI program years, we propose to retain the following 2 criteria with respect to satisfactorily reporting data on individual quality measures in circumstances where 3 or more individual quality measures apply to the services furnished by an eligible professional:

- Report on at least 3 2010 PQRI measures (unless fewer than 3 2010 PQRI measures apply to the services furnished by the eligible professional); and
- Report each measure for at least 80 percent of the eligible professional's Medicare Part B FFS patients for whom services were furnished during the reporting period to which the measure applies.

These criteria would apply to all proposed 2010 PQRI reporting mechanisms available for reporting individual PQRI quality measures (that is, claims-based reporting, registry-based reporting, and EHR-based reporting).

If an eligible professional has fewer than 3 PQRI measures that apply to the professional's services, then the professional would be able to meet the criteria for satisfactorily reporting data on individual quality measures by meeting the following 2 proposed criteria:

- Reporting on all measures that apply to the services furnished by the professional (that is 1 to 2 measures); and
- Reporting each measure for at least 80 percent of the eligible professional's Medicare Part B FFS patients for whom services were furnished during the reporting period to which the measure applies.

We propose that, as in previous years, these criteria for satisfactorily reporting data on fewer than 3 individual quality measures would be available for the claims-based reporting mechanism only. An eligible professional who has fewer than 3 PQRI measures that apply to the professional's services would not be able to meet the criteria for satisfactory reporting by reporting on all applicable measures (that is, 1 or 2 measures) through the registry-based reporting mechanism.

While we have received input from several stakeholders requesting that we permit an eligible professional to report fewer than 3 measures through the registry-based reporting mechanism if fewer than 3 measures apply to him or her, doing so would be inefficient. First, in addition to needing to analyze the data submitted to us by the registry, we would have to analyze the claims data to ensure that no additional measures are applicable to the eligible professional, much like what we do under the Measure Applicability Validation process for claims-based reporting. Second, we would also have to analyze the claims data to ensure that the eligible professional had not attempted to report additional measures through claims. For these reasons, we are not proposing to permit eligible professionals who choose the registry-based or EHR-based reporting mechanism to report on individual quality measures to report on fewer than 3 measures if only 1 or 2 measures apply to the services they furnish.

Based on the previously stated assumption that a measure applies to the eligible professional if an eligible professional submits quality data codes for a particular measure, we propose that an eligible professional who reports on fewer than 3 measures through the claims-based reporting mechanism in 2010 may be subject to the Measure Applicability Validation process, which allows us to determine whether an eligible professional should have reported quality data codes for additional measures. This process was applied in the 2007 and 2008 PQRI. When an eligible professional reports on fewer than 3 measures, we propose to review whether there are other closely related measures (such as those that share a common diagnosis or those that are representative of services typically provided by a particular type of professional). If an eligible professional who reports on fewer than 3 measures in 2010 reports on a measure that is part of an identified cluster of closely related measures and did not report on any other measure that is part of that identified cluster of closely related measures, then the professional would not qualify to receive a 2010 PQRI incentive payment. Additional information on the Measure Applicability Validation process can be found on the Analysis and Payment page of the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI.*

In addition to the above criteria related to the number of measures on which an eligible professional would be required to report and the frequency of reporting, we propose a third criterion for satisfactory reporting of individual measures. Based on our authority to revise the criteria for satisfactory reporting under section 1848(m)(3)(D) of the Act, we propose that an eligible professional also be required to report data on at least one individual measure on a minimum number of Medicare Part B FFS patients seen during the reporting period, as detailed below. Establishing a minimum patient sample size requirement would enhance the scientific validity of eligible professionals' performance results and encourage eligible professionals to select to report only measures that are representative of the types of services they typically provide in their practice. If, for example, an eligible professional selects 3 patient-level measures (that is, measures in which the required

reporting frequency is a minimum of once per reporting period per individual eligible professional) where only one of his or her Medicare Part B FFS patients are eligible for the measures and there is no minimum patient sample size requirement, then the eligible professional currently could qualify to earn a PQRI incentive payment by reporting PQRI quality measures data only 3 times during the entire reporting period. We believe that information on such a small sample of cases would be insufficient to do any meaningful analysis of the eligible professional's performance on the reported measure. We also believe that a minimum patient sample size requirement would prevent an eligible professional from purposely selecting measures that apply to only a few of their patients.

Regardless of the reporting mechanism chosen by the eligible professional, we propose that the minimum patient sample size for reporting individual quality measures be 15 Medicare Part B FFS patients for the 12-month reporting period. An eligible professional would need to meet this minimum patient sample size requirement for at least one measure on which the eligible professional chooses to report. This proposed number is based on our experience with the 2007 PQRI and the limited information we have available regarding the 2008 PQRI reporting experience. For the 2007 PQRI measures, where the only reporting period was a 6-month reporting period beginning July 1, 2007, the median number of instances in which an eligible professional could have reported a 2007 PQRI measure was, on average, 9 eligible instances per measure. If we assume that the number of eligible instances for the first half of 2007 were similar to the number of eligible instances in the second half of 2007, then we can assume that the median number of eligible instances was an average of 18 instances per measure for the entire year. Preliminary information from the 2008 PQRI, based on data through September 2008, indicate that the median number of instances in which an eligible professional could have reported a 2008 PQRI measure was, on average, 18 eligible instances per measure. Since eligible professionals are not required to report a measure for all eligible cases, we based the proposed minimum patient sample size threshold on 80 percent of 18 eligible instances, which is 14.4.

Similarly, for the 6-month reporting period (available for registry-based reporting only), we propose that the minimum patient sample size for reporting on individual quality measures be 8 Medicare Part B FFS patients seen during the 6-month reporting period. An eligible professional would need to meet this minimum patient sample size requirement for at least one measure on which the eligible professional chooses to report. We welcome comments on the proposal to add a minimum patient sample size criterion to the criteria for satisfactory reporting of data on individual quality measures. In addition, we invite comments on the specific thresholds proposed for the 12-month reporting period (available for claims-based, registry-based, and EHR-based reporting) and for the 6-month reporting period (available for registry-based reporting only) for reporting individual quality measures.

The proposed 2010 criteria for satisfactory reporting of data on individual PQRI quality measures are summarized in Table 14 and are arranged by reporting mechanism and reporting period.

TABLE 14—PROPOSED 2010 CRITERIA FOR SATISFACTORY REPORTING OF DATA ON INDIVIDUAL PQRI QUALITY MEASURES, BY REPORTING MECHANISM AND REPORTING PERIOD

Reporting mechanism	Reporting criteria	Reporting period
Claims-based reporting	• Report at least 3 PQRI measures, or 1–2 measures if less than 3 measures apply to the eligible professional; • Report each measure for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measure applies; and • Report at least 1 PQRI measure on at least 15 Medicare Part B FFS patients seen during the reporting period to which the measure applies.	January 1, 2010–December 31, 2010.
Registry-based reporting	• Report at least 3 PQRI measures; • Report each measure for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measure applies; and • Report at least 1 PQRI measure on at least 15 Medicare Part B FFS patients seen during the reporting period to which the measure applies.	January 1, 2010–December 31, 2010.
Registry-based reporting	• Report at least 3 PQRI measures; • Report each measure for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measure applies; and • Report at least 1 PQRI measure on at least 8 Medicare Part B FFS patients seen during the reporting period to which the measure applies.	July 1, 2010–December 31, 2010.
EHR-based reporting	• Report at least 3 PQRI measures; • Report each measure for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measure applies; and • Report at least 1 PQRI measure on at least 15 Medicare Part B FFS patients seen during the reporting period to which the measure applies.	January 1, 2010–December 31, 2010.

As illustrated in Table 14, there are a total of 4 proposed reporting options, or ways in which an eligible professional may meet the criteria for satisfactory reporting on individual quality measures for the 2010 PQRI. Each reporting option consists of the criteria for satisfactorily reporting such data and results on individual quality measures relevant to a given reporting mechanism and reporting period. While eligible professionals may potentially qualify as satisfactorily reporting individual quality measures under more than one of the proposed reporting criteria, proposed reporting mechanisms, and/or for more than one proposed reporting period, only one incentive payment would be made to an eligible professional based on the longest reporting period for which the eligible professional satisfactorily reports.

f. Proposed Criteria for Satisfactory Reporting Measures Groups for Individual Eligible Professionals

As described above, section 1848(m)(5)(F) of the Act requires that, for 2008 and subsequent years, the Secretary establish alternative reporting periods and alternative criteria for satisfactorily reporting groups of measures. In establishing these alternatives in prior years, we have labeled these groups of measures ''measures groups.'' We have previously defined ''measures groups'' as a subset of four or more PQRI measures that have a particular clinical condition or focus in common. The denominator definition and coding of the measures group identifies the condition or focus that is shared across the measures within a particular measures group.

In the 2008 and 2009 PQRI, measures groups were reportable through claims-based or registry-based reporting. For the 2008 and 2009 PQRI, there were 2 basic sets of criteria for satisfactory reporting measures groups through claims-based or registry-based reporting: (1) The reporting of at least 1 measures group for at least 80 percent of patients to whom the measures group applies during the reporting period; or (2) the reporting of at least 1 measures group for a specified number of consecutive patients to whom the measures group applies during the reporting period. For registry-based reporting in the 2008 and 2009 PQRI, we allowed eligible professionals to include some non-Medicare Part B FFS patients in the consecutive patient sample under the second set of criteria. For registry-based reporting quality measures results and numerator and denominator data on measures groups in 2009, we also added to the first set of criteria a requirement to report the measures group on a minimum number of patients commensurate with the reporting period duration.

For the 2010 PQRI, we again propose 2 basic sets of criteria for satisfactory reporting on measures group. Both sets of criteria would apply to the claims-based and registry-based reporting mechanism. As discussed in section II.G.2.d.(3) of this proposed rule, we are not proposing to make the EHR-based reporting mechanism available for reporting on measures groups in 2010.

The first set of proposed criteria, which we propose to make available for either the 12-month or 6-month reporting period in 2010, would be consistent with the 2009 criteria for satisfactory reporting of measures groups through registry-based reporting, which require the reporting of at least 1 measures group for at least 80 percent of patients to whom the measures group applies during the applicable reporting period (with reporting required on a minimum number of Medicare Part B FFS patients commensurate with the reporting period duration). In the 2009 PQRI, there was a requirement under these criteria to report each measures group on at least 30 Medicare Part B FFS patients for the 12-month reporting period and at least 15 Medicare Part B FFS patients for the 6-month reporting period for registry-based reporting of measures groups. For the 2010 PQRI, we propose to revise the requirement by making these criteria applicable to both registry-based and claims-based reporting and to change the number of Medicare Part B FFS patients on which an eligible professional would be required to report a measures group. We propose to require an eligible professional who chooses to report on measures groups based on reporting on 80 percent of applicable patients to report on a minimum of 15 Medicare Part B FFS patients for the 12-month reporting period and a minimum of 8 Medicare Part B FFS patients for the 6-month reporting period, regardless of whether the eligible professional chooses to report the measures group through claims-based reporting or registry-based reporting. We propose to revise the required minimum sample size to make the proposed 2010 criteria for satisfactory reporting of measures groups consistent with the proposed 2010 criteria for satisfactory reporting of individual measures. We invite comments on our proposal to make the criteria for satisfactory reporting of measures groups more consistent with those proposed for reporting individual measures. We especially would be interested in comments with respect to our proposal to revise the minimum sample size requirement related to satisfactory reporting on measures group through the registry-based reporting mechanism so that the criteria for satisfactory reporting of measures groups, regardless of reporting mechanism, would be identical to those proposed for reporting individual measures.

The second set of proposed criteria, which we propose to make available for the 12-month reporting period only, would be based on reporting on a measures group on a specified minimum number of patients. The second set of criteria would require reporting on at least 1 measures group for at least 30 patients seen between January 1, 2010 and December 31, 2010 to whom the measures group applies. Unlike the 2009 PQRI, which required that eligible professionals report on consecutive patients (that is, patients seen in order, by date of service), the 30 patients on which an eligible professional would need to report a measures group for 2010 would not need to be consecutive patients. The eligible professional would be able to report on any 30 patients seen during the reporting period to which the measures group applies. We propose to remove the requirement to report on patients seen consecutively by date of service because our preliminary analysis of the 2008 PQRI claims-based reporting experience through September 2008 suggests that this requirement is difficult for professionals to apply accurately to meet the criteria for satisfactory reporting of measures groups. In addition, the questions we receive from eligible professionals indicate that many eligible professionals are not clear on how to determine which patients are ''consecutive'' and should be included in the patient sample. We believe that any adverse effect on the reliability or validity of the quality information received as a result of the removal of the requirement to report on patients seen consecutively and allowing eligible professionals to report on any 30 patients would be minimal. When eligible professionals report measures groups, they are required to report on multiple measures for a given clinical condition or focus, which makes it harder for them to selectively choose patients in an attempt to improve their performance results. We invite comments on our proposal to allow eligible professionals to report on measures groups on any 30 patients rather than a consecutive patient sample.

As in previous years, we propose that for 2010, the patients, for claims-based

reporting, would be limited to Medicare Part B FFS patients. We receive claims on Medicare patients only. For registry-based reporting, however, we propose that the patients could include some, but not be exclusively, non-Medicare Part B FFS patients.

The proposed 2010 criteria for satisfactory reporting on measures groups are summarized in Table 15, which is arranged by reporting mechanism and reporting period.

TABLE 15—PROPOSED 2010 CRITERIA FOR SATISFACTORY REPORTING ON MEASURES GROUPS, BY REPORTING MECHANISM AND REPORTING PERIOD

Reporting mechanism	Reporting criteria	Reporting period
Claims-based reporting	• Report at least 1 PQRI measures group; • Report each measures group for at least 30 Medicare Part B FFS patients.	January 1, 2010–December 31, 2010.
Claims-based reporting	• Report at least 1 PQRI measures group; • Report each measures group for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; and • Report each measures group on at least 15 Medicare Part B FFS patients seen during the reporting period to which the measures group applies.	January 1, 2010–December 31, 2010.
Claims-based reporting	• Report at least 1 PQRI measures group; • Report each measures group for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; and • Report each measures group on at least 8 Medicare Part B FFS patients seen during the reporting period to which the measures group applies.	July 1, 2010–December 31, 2010. January 1, 2010–December 31, 2010.
Registry-based reporting	• Report at least 1 PQRI measures group; • Report each measures group for at least 30 patients. Patients may include, but may not be exclusively, non-Medicare Part B FFS patients.	January 1, 2010–December 31, 2010.
Registry-based reporting	• Report at least 1 PQRI measures group; • Report each measures group for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; and • Report each measures group on at least 15 Medicare Part B FFS patients seen during the reporting period to which the measures group applies.	January 1, 2010–December 31, 2010.
Registry-based reporting	• Report at least 1 PQRI measures group; • Report each measures group for at least 80 % of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; and • Report each measures group on at least 8 Medicare Part B FFS patients seen during the reporting period to which the measures group applies.	July 1, 2010–December 31, 2010.

As illustrated in Table 15, there are a total of 6 proposed reporting options, or ways in which an eligible professional may meet the proposed criteria for satisfactory reporting of measures groups for the 2010 PQRI. Each reporting option consists of the criteria for satisfactory reporting relevant to a given reporting mechanism and reporting period. As stated previously, while eligible professionals may potentially qualify as satisfactorily reporting on measures groups under more than one of the proposed reporting criteria, proposed reporting mechanisms, and/or for more than one proposed reporting period, only one incentive payment would be made to an eligible professional based on the longest reporting period for which the eligible professional satisfactorily reports.

g. Proposed Reporting Option for Satisfactory Reporting on Quality Measures by Group Practices

As stated previously, section 1848(m)(3)(C)(i) of the Act requires the Secretary to establish and have in place a process by January 1, 2010 under which eligible professionals in a group practice (as defined by the Secretary) shall be treated as satisfactorily submitting data on quality measures under PQRI if, in lieu of reporting measures under PQRI, the group practice reports measures determined appropriate by the Secretary, such as measures that target high-cost chronic conditions and preventive care, in a form and manner, and at a time specified by the Secretary. Section 1848(m)(3)(C)(ii) of the Act requires that this process provide for the use of a statistical sampling model to submit data on measures, such as the model used under the Medicare Physician Group Practice (PGP) demonstration project under section 1866A of the Act.

In addition, payments to a group practice under section 1848(m) of the Act by reason of the process proposed herein shall be in lieu of the PQRI incentive payments that would otherwise be made to eligible professionals in the group practice for satisfactorily submitting data on quality measures (that is, prohibits double payments). Therefore, in addition to making incentive payments for 2010 to group practices based on separately analyzing whether the individual eligible professionals within the group practice (that is, for each TIN/NPI combination) satisfactorily reported on PQRI quality measures, we will begin making incentive payments to group practices based on the determination that the group practice, as a whole (that is, for the TIN), satisfactorily reports on

PQRI quality measures for 2010. In addition, an individual eligible professional who is affiliated with a group practice participating in the group practice reporting option that satisfactorily reports under the proposed group practice reporting option would not be eligible to earn a separate PQRI incentive payment for 2010 on the basis of his or her satisfactorily reporting PQRI quality measures data at the individual level.

(1) Definition of ''Group Practice''

As stated above, section 1848(m)(3)(C)(i) of the Act authorizes the Secretary to define ''group practice.'' For purposes of determining whether a group practice satisfactorily submits PQRI quality measures data, we propose that a ''group practice'' would consist of a physician group practice, as defined by a TIN, with at least 200 or more individual eligible professionals (or, as identified by NPIs) who have reassigned their billing rights to the TIN.

Generally, our intent is to build on an existing quality reporting program that group practices may already be familiar with by modeling the PQRI group practice reporting option after the PGP demonstration. Since the PGP demonstration is a demonstration program for large group practices, one of the requirements for group practices participating in the PGP demonstration is for each practice to have 200 or more members. To be consistent with the PGP demonstration, we also propose to limit initial implementation of the PQRI group practice reporting option for 2010 to similar large group practices. As we gain more experience with the group practice reporting option, we may consider lowering the group size threshold in the future. We invite comments on the proposed definition of ''group practice'' and our proposal to limit initial implementation of the PQRI group practice reporting option in 2010 to practices with 200 or more individual eligible professionals.

In order to participate in the 2010 PQRI through the group practice reporting option, we propose to require group practices to complete a self-nomination process and to meet certain technical and other requirements. Group practices interested in participating in the 2010 PQRI through the group practice reporting option would be required to submit a self-nomination letter to CMS or a CMS designee requesting to participate in the 2010 PQRI group practice reporting option. We propose that each group practice would be required to meet the following requirements:

- Have an active Individuals Access to CMS Systems (IACS) user account;
- Provide CMS or a CMS designee with the group practice's TIN and the NPI numbers and names of all eligible professionals who will be participating as part of the group practice (that is, all individual NPI numbers associated with the group practice's TIN). This information must be provided in an electronic format specified by CMS, such as in an Excel spreadsheet; and
- Agree to have the group practice's PQRI quality measurement performance rates for each measure publicly reported by posting of the results on a CMS Web site.

We propose to post the final participation requirements for group practices, including the exact date by which group practices that wish to participate in the 2010 PQRI through the group practice reporting option must submit a self-nomination letter and other instructions for submitting the self-nomination letter, on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI* by November 15, 2009. We anticipate that group practices that wish to self-nominate for 2010 will be required to do so by the end of the first quarter of 2010, but not later than the end of the second quarter of 2010. Upon receipt of the self-nomination letters we will assess whether the participation requirements proposed above have been met by each self-nominated group practice.

(2) Process for Physician Group Practices To Participate as Group Practices and Criteria for Satisfactory Reporting Data on Quality Measures by Group Practices

For physician groups selected to participate in the PQRI group practice reporting option for 2010, we propose the reporting period would be the 12-month reporting period beginning January 1, 2010. We propose that group practices would be required to submit information on these measures using a data collection tool based on the data collection tool used in CMS' Medicare Care Management Performance (MCMP) demonstration and the quality measurement and reporting methods used in CMS' PGP demonstration. We propose that physician groups selected to participate in the 2010 PQRI through the group practice reporting option would be required to report on a common set of 26 NQF-endorsed quality measures that are based on measures currently used in the MCMP and/or PGP demonstration and that target high-cost chronic conditions and preventive care. These quality measures are identified in Table 34. Additional information on the MCMP and PGP demonstrations is posted on the Medicare Demonstrations section of the CMS Web site at *http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/list.asp#TopOfPage*. Although our proposed process for physician groups to participate in PQRI as a group practice incorporates some characteristics and methods from the PGP demonstration and the MCMP demonstration, the PQRI group practice reporting option will be a separate program with its own specifications and methodology from the PGP and MCMP demonstration programs.

The proposed quality measures identified in Table 34 are based on a subset of the Doctor's Office Quality (DOQ) quality measures set developed and specified under the direction of CMS and which are used in the PGP and/or MCMP demonstration programs. Contributors to the development of the DOQ measure set included the American Medical Association's Physician Consortium for Performance Improvement (AMA-PCPI), the American College of Cardiology (ACC), the American Heart Association (AHA), the National Diabetes Quality Improvement Alliance, the National Committee for Quality Assurance (NCQA), and the Veterans Health Administration (VA) and, in most instances, overlap with proposed 2010 PQRI measures. These quality measures are grouped into four disease modules: diabetes; heart failure; coronary artery disease; and preventive care services.

As part of the data submission process, we propose that, beginning in 2011, each group practice would be required to report quality measures with respect to services furnished during the 2010 reporting period (that is, January 1, 2010 through December 31, 2010) on an assigned sample of Medicare beneficiaries. We propose to analyze the January 1, 2010 through October 29, 2010 (that is, the last business day of October 2010) National Claims History (NCH) file to assign Medicare beneficiaries to each physician group practice using the same patient assignment methodology used in the PGP demonstration. Assigned beneficiaries are limited to those Medicare FFS beneficiaries with Medicare Parts A and B for whom Medicare is the primary payer. Assigned beneficiaries do not include Medicare Advantage enrollees. Essentially, a beneficiary would be assigned to the physician group that provides the plurality of a beneficiary's office or other outpatient E/M allowed charges (based on Medicare Part B claims submitted for the beneficiary for dates of services between January 1, 2010 and October 29, 2010). Beneficiaries with

only 1 visit to the group practice between January 1, 2010 and October 29, 2010 would be eliminated from the group practice's assigned patient sample. Once the beneficiary assignment has been made for each physician group, each physician group would be required to report the quality measures on a random sample of the assigned beneficiaries per disease module or preventive care measure. For each disease module or preventive care measure, the physician group would be required to report information on the assigned patients in the order in which they appear in the group's sample (that is, consecutively). In the fourth quarter of 2010, we would pull a random sample of assigned beneficiaries for each disease module or preventive care measure and provide the sample to the physician group consistent with the methods used in the PGP demonstration. Identical to the sampling method used in the PGP demonstration, the random sample must consist of at least 411 assigned beneficiaries. If the pool of eligible assigned beneficiaries is less than 411, then the group practice must report on 100 percent of the assigned beneficiaries to participate in the group practice reporting option.

We propose a unique reporting mechanism for the group practice reporting option that would not be available to individual eligible professionals participating in the 2010 PQRI. We propose that each physician group selected to participate in the group practice reporting option would have access to a database (that is, a data collection tool) that would include the assigned beneficiary sample and the quality measures. This data collection tool was originally developed for use in the PGP demonstration, updated for use in the MCMP demonstration, and would be updated as needed for use in the PQRI. The assigned beneficiaries' demographic and utilization information would be prepopulated based on claims data. We anticipate being able to provide the selected physician groups with access to this prepopulated database by the fourth quarter of 2010. The physician group would be required to populate the remaining data fields necessary for capturing quality measure information on each of the assigned beneficiaries. Numerators for each of the quality measures would include all beneficiaries in the denominator population who also satisfy the quality performance criteria for that measure. Denominators for each quality measure would include a sample of the assigned beneficiaries who meet the eligibility criteria for that quality measure module or preventive care measure.

We invite comments on our proposal to adopt the PGP demonstration's quality measurement and reporting methods for the PQRI group practice reporting option. We specifically request comments on the proposed patient assignment methodology and our proposal to use a data collection tool based on the one used in the MCMP demonstration as the reporting mechanism for physician groups selected to participate in the PQRI group practice reporting option.

We propose 2 criteria for satisfactory reporting of quality measures by a physician group. First, the physician group would be required to report completely on all of the proposed modules and measures listed in Table 34. Second, the physician group would be required to report on the first 411 consecutively assigned Medicare beneficiaries per disease module or preventive care measure. This is identical to the reporting criteria used in the PGP demonstration. By building on an existing demonstration program that large group practices may already have experience with, we hope to minimize burden on both group practices and CMS. The sample that we pull for and provide to each physician group would include more than the 411 assigned beneficiaries (the sample would include an over sample of approximately 50 percent). More beneficiaries are provided in the sample than the group practice is required to report on in order to account for beneficiaries included in the sample who cannot be confirmed with the diagnosis for a particular disease module or whose medical information may not be able to be located within the physician group's systems.

h. Statutory Requirements and Other Considerations for Measures Proposed for Inclusion in the 2010 PQRI

(1) Statutory Requirements for Measures Proposed for Inclusion in the 2010 PQRI

As a result of section 131(b) of the MIPPA, the statutory requirements with respect to the use of quality measures for the 2010 PQRI are different from the statutory requirements for previous program years. For the 2007 PQRI, section 1848(k)(2)(A)(i) of the Act required the Secretary to generally select the quality measures identified as 2007 physician quality measures under the Physician Voluntary Reporting Program. For the 2008 and 2009 PQRI, section 1848(k)(2)(B) of the Act required that the quality measures be measures that have been adopted or endorsed by a consensus organization (such as the National Quality Forum or AQA), that include measures that have been submitted by a physician specialty, and that the Secretary identifies as having used a consensus-based process for developing such measures. For purposes of reporting data on quality measures for covered professional services furnished during 2010 and subsequent years for the PQRI, subject to the exception noted below, section 1848(k)(2)(C)(i) of the Act, as added by MIPPA, requires that the quality measures shall be such measures selected by the Secretary from measures that have been endorsed by the entity with a contract with the Secretary under subsection 1890(a) of the Act, as added by section 183 of the MIPPA. On January 14, 2009, the U.S. Department of Health and Human Services awarded the contract required under section 1890(a) of the Act to the National Quality Forum (NQF).

In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the NQF, however, section 1848(k)(2)(C)(ii) of the Act authorizes the Secretary to specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary, such as the AQA alliance. In light of these statutory requirements, we believe that, except in certain specified circumstances, each proposed 2010 PQRI quality measure would need to be endorsed by the NQF by July 1, 2009. In those circumstances in which a feasible and practical measure has not been endorsed by the NQF, we believe that all other proposed 2010 PQRI quality measures would need to have at least been adopted by the AQA or another organization with comparable consensus-organization characteristics. However, in January 2009, the AQA announced that it will no longer be adopting measures and we are not aware of any other organizations with consensus-organization characteristics (*see* 73 FR 38565 through 38566 for discussion of the considerations applied in determining whether an entity is a consensus organization). Therefore, our policy with respect to identifying exceptions under section 1848(k)(2)(C)(ii) of the Act would be to give due consideration to measures that have been endorsed by the NQF. As a result, in reviewing measures for possible inclusion in the 2010 PQRI quality measure set, we propose that any new quality measures proposed for the 2010 PQRI must be NQF-endorsed

by July 1, 2009, while any proposed 2010 PQRI quality measures selected from the 2009 PQRI quality measure set would need to have been adopted by the AQA as of January 31, 2009, if the measure still is not endorsed by the NQF by July 1, 2009.

In addition, section 1848(k)(2)(D) of the Act requires that for each 2010 PQRI quality measure, ''the Secretary shall ensure that eligible professionals have the opportunity to provide input during the development, endorsement, or selection of measures applicable to services they furnish.'' Measure developers generally include a public comment phase in their measure development process. As part of the measure development process, measure developers typically solicit public comments on measures that they are testing in order to determine whether additional refinement of the measure(s) is needed prior to submission for consensus endorsement. For example, information on the measure development process employed by us when CMS or a CMS contractor is the measure developer is available in the ''Measures Management System Blueprint'' found on the CMS Web site at *http://www.cms.hhs.gov/apps/QMIS/mmsBlueprint.asp*.

Eligible professionals also have the opportunity to provide input on a measure as the measure is being vetted through the NQF consensus endorsement process (and previously, the AQA consensus adoption process). In particular, the NQF employs a public comment period for measures vetted through its consensus endorsement process (and previously, for the AQA, its consensus adoption process).

Finally, eligible professionals have an opportunity to provide input on the measures proposed for inclusion in the 2010 PQRI through this proposed rule, which provides a 60-day comment period. Accordingly, with regard to the 2010 PQRI, we believe we have satisfied this requirement in multiple ways.

(2) Other Considerations for Measures Proposed for Inclusion in the 2010 PQRI

Consistent with the statutory requirements described in section II.G.2.h.(1) of this proposed rule, we propose to apply the following considerations with respect to the selection of 2009 PQRI quality measures proposed for inclusion in the 2010 PQRI quality measure set:

- Where some 2009 PQRI quality measures have been endorsed by the NQF and others have not, those 2009 PQRI quality measures that have been specifically considered by NQF for possible endorsement, but NQF has declined to endorse it, are not proposed for inclusion in the 2010 PQRI quality measure set (that is, we propose to retire the measure for 2010).
- In circumstances where no NQF-endorsed measure is available, we propose to exercise the exception under section 1848(k)(2)(C)(ii) of the Act. Under these circumstances, a 2009 PQRI quality measure that previously (that is, prior to January 31, 2009) has been adopted by the AQA would meet the requirements under the Act and we propose that it would be appropriate for eligible professionals to use the measure to submit quality measures data and/or quality measures results and numerator and denominator data on quality measures, as appropriate.
- Although we do not propose to include any 2009 PQRI measures that have not been endorsed by the NQF or adopted by the AQA in the final 2010 PQRI quality measure set, we acknowledge that section 1848(k)(C)(ii) of the Act provides an exception to the requirement that the Secretary select measures that have been endorsed by the entity with a contract under section 1890(a) of the Act (that is, the NQF) as long as an area or medical topic for which a feasible and practical NQF-endorsed measure is not available has been identified and due consideration has been given to measures that have been endorsed by the NQF and/or, prior to January 31, 2009, adopted by the AQA.
- The statutory requirements under section 1848(k)(2)(C) of the Act, subject to the exception noted above, require only that the measures be selected from measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a) (that is, the NQF) and are silent with respect to how the measures that are submitted to the NQF for endorsement were developed. The basic steps for developing measures applicable to physicians and other eligible professionals prior to submission of the measures for endorsement may be carried out by a variety of different organizations. We do not believe there needs to be any special restrictions on the type or make up of the organizations carrying out this basic development of physician measures, such as restricting the initial development to physician-controlled organizations. Any such restriction would unduly limit the basic development of quality measures and the scope and utility of measures that may be considered for endorsement as voluntary consensus standards.
- 2009 PQRI measures that were part of the 2007 and/or 2008 PQRI in which the 2007 and 2008 PQRI analytics indicate a lack of significant reporting and usage were not considered for inclusion in the 2010 PQRI.

In addition to reviewing the 2009 PQRI measures and previously retired measures, for purposes of developing the proposed 2010 PQRI measures, we have reviewed and considered measure suggestions including comments received in response to the CY 2009 PFS proposed rule and final rule with comment period. Additionally, suggestions and input received through other venues, such as an invitation for measures suggestions posted on the PQRI section of the CMS Web site in February 2009 were also reviewed and considered for purposes of our development of the list of proposed 2010 PQRI quality measures.

With respect to the selection of new measures (that is, measures that have never been selected as part of a PQRI quality measure set for 2009 or any prior year), we propose to apply the following considerations, which include many of the same considerations applied to the selection of 2009 PQRI quality measures for proposed inclusion in the 2010 PQRI quality measure set described above:

- High Impact on Healthcare.
- Measures that are high impact and support CMS and HHS priorities for improved quality and efficiency of care for Medicare beneficiaries. These current and long term priority topics include: Prevention; chronic conditions; high cost and high volume conditions; elimination of health disparities; healthcare-associated infections and other conditions; improved care coordination; improved efficiency; improved patient and family experience of care; improved end-of-life/palliative care; effective management of acute and chronic episodes of care; reduced unwarranted geographic variation in quality and efficiency; and adoption and use of interoperable HIT.
- Measures that are included in, or facilitate alignment with, other Medicare, Medicaid, and CHIP programs in furtherance of overarching healthcare goals.
- NQF Endorsement.

+ Measures must be NQF-endorsed by July 1, 2009 in order to be considered for inclusion in the 2010 PQRI quality measure set.

+ Although we do not propose to include any new measures that are not endorsed by the NQF by July 1, 2009 in the final 2010 PQRI quality measure set, we acknowledge that section (k)(2)(C)(ii) of the Act provides an exception to the requirement that the Secretary select measures that have been endorsed by the entity with a contract under section 1890(a) of the Act (that is, the NQF). As

long as an area or medical topic for which a feasible and practical NQF-endorsed measure is not available has been identified and due consideration has been given to measures that have been adopted by the AQA or other consensus organization identified by Secretary.

+ The statutory requirements under section 1848(k)(2)(C) of the Act, subject to the exception noted above, require only that the measures be selected from measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a) (that is, the NQF) and are silent with respect to how the measures that are submitted to the NQF for endorsement were developed. The basic steps for developing measures applicable to physicians and other eligible professionals prior to submission of the measures for endorsement may be carried out by a variety of different organizations. We do not believe there needs to be any special restrictions on the type or make up of the organizations carrying out this basic development of physician measures, such as restricting the initial development to physician-controlled organizations. Any such restriction would unduly limit the basic development of quality measures and the scope and utility of measures that may be considered for endorsement as voluntary consensus standards. The requirements under section 1848(k)(2)(C) of the Act pertain only to the selection of measures and not to the development of measures.

• Address Gaps in PQRI Measure Set.

+ Measures that increase the scope of applicability of the PQRI measures to services furnished to Medicare beneficiaries and expand opportunities for eligible professionals to participate in PQRI. We seek to achieve broad ability to assess the quality of care furnished to Medicare beneficiaries, and ultimately to compare performance among professionals. We seek to increase the circumstances where eligible professionals have at least 3 measures applicable to their practice and measures that help expand the number of measures groups with at least four measures in a group.

• Measures of various aspects of clinical quality including outcome measures, where appropriate and feasible, process measures, structural measures, efficiency measures, and measures of patient experience of care.

Other considerations that we propose to apply to the selection of measures for 2010, regardless of whether the measure is a 2009 PQRI measure or not, are:

• Measures that are functional, which is to say measures that can be technically implemented within the capacity of the CMS infrastructure for data collection, analysis, and calculation of reporting and performance rates. This leads to preference for measures that reflect readiness for implementation, such as those that are currently in the 2009 PQRI program or have been through testing. The purpose of measure testing is to reveal the measure's strengths and weaknesses so that the limitations can be addressed and the measure refined and strengthened prior to implementation. For new measures, preference is given to those that can be most efficiently implemented for data collection and submission. Therefore, any measures that have been found to be technically impractical to report because they are analytically challenging due to any number of factors, including those that are claims-based, have not been included in the 2010 PQRI. For example, in some cases, we have proposed to replace existing 2009 PQRI measures with updated and improved measures that are less technically challenging to report.

• For some measures that are useful, but where data submission is not feasible through all otherwise available PQRI reporting mechanisms, a measure may be included for reporting solely through specific reporting mechanism(s) in which its submission is feasible. For example, we are proposing to limit reporting of some measures that previously were available for claims-based reporting and registry-based reporting to registry-based reporting only because they were technically challenging to report and/or analyze through the claims-based reporting mechanism. For further discussion of the proposed reporting mechanisms, *see* section II.G.2.d. of this proposed rule.

We also reviewed 33 measures that have been retired from the PQRI in previous years using the considerations for selecting proposed measures for the 2010 PQRI discussed above. None were found to be eligible for inclusion in the 2010 PQRI quality measure set because they did not meet the criteria described above.

We welcome comments on the implication of including or excluding any given measure or measures proposed herein in the final 2010 PQRI quality measure set and on our approach in selecting measures. We recognize that some commenters may also wish to recommend additional measures for inclusion in the 2010 PQRI measures that we have not herein proposed. While we welcome all constructive comments and suggestions, and may consider such recommended measures for inclusion in future measure sets for PQRI and/or other programs to which such measures may be relevant, we will not be able to consider such additional measures for inclusion in the 2010 measure set.

As discussed above, section 1848(k)(2)(D) of the Act requires that the public have the opportunity to provide input during the selection of measures. We also are required by other applicable statutes to provide opportunity for public comment on provisions of policy or regulation that are established via notice and comment rulemaking. Measures that were not included in this proposed rule for inclusion in the 2010 PQRI that are recommended to CMS via comments on this proposed rule have not been placed before the public with opportunity for the public to comment on the selection of those measures within the rulemaking process. Even when measures have been published in the **Federal Register**, but in other contexts and not specifically proposed as PQRI measures, such publication does not provide true opportunity for public comment on those measures' potential inclusion in PQRI. Thus, such additional measures recommended for selection for the 2010 PQRI via comments on this proposed rule cannot be included in the 2010 measure set. However, as discussed above, we will consider comments and recommendations for measures, which may not be applicable to the final set of 2010 PQRI measures, for purposes of identifying measures for possible use in future years' PQRI or other initiatives to which those measures may be pertinent.

In addition, as in prior years, we note that we do not use notice and comment rulemaking as a means to update or modify measure specifications. Quality measures that have completed the consensus process have a designated party (usually, the measure developer/owner) who has accepted responsibility for maintaining the measure. In general, it is the role of the measure owner, developer, or maintainer to make changes to a measure. Therefore, comments requesting changes to a specific proposed PQRI measure's title, definition, and detailed specifications or coding should be directed to the measure developer identified in Tables 16 through 34. Contact information for the 2009 PQRI measure developers is listed in the ''2009 PQRI Quality Measures List,'' which is available on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI.*

i. Proposed 2010 PQRI Quality Measures for Individual Eligible Professionals

As stated previously, individual eligible professionals have the choice of reporting PQRI quality measures data on either individual quality measures or on measures groups.

Consistent with the statutory requirements for measures included in the 2010 PQRI and other considerations for identifying proposed 2010 quality measures discussed in section II.G.2.h.(1) and II.G.2.h.(2), respectively, of this proposed rule, the individual quality measures identified for use in the 2010 PQRI will be selected from those we propose in this rule and will be finalized as of the date the CY 2010 PFS final rule with comment period goes on display at the Office of the Federal Register. No changes (that is, additions or deletions of measures) will be made after publication of the CY 2010 PFS final rule with comment period. However, as was the case for 2008 and 2009, we may make modifications or refinements, such as revisions to measures titles and code additions, corrections, or revisions to the detailed specifications for the 2010 measures until the beginning of the reporting period. Such specification modifications may be made through the last day preceding the beginning of the reporting period. The 2010 measures specifications for individual quality measures will be available on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI* when they are sufficiently developed or finalized. We are targeting finalization and publication of the detailed specifications for all 2010 PQRI measures on the PQRI section of the CMS Web site by November 15, 2009 and will, in no event, publish these specifications later than December 31, 2009. The detailed specifications will include instructions for reporting and identify the circumstances in which each measure is applicable.

For 2010, we are proposing that final PQRI quality measures will be selected from 153 of the 2009 PQRI measures and 149 measure suggestions received in response to the February 2009 invitation to submit suggestions for measures and measures groups for possible inclusion in the 2010 PQRI (that is, the ''Call for 2010 Measure Suggestions''). We propose to include a total of 168 measures (this includes both individual measures and measures that are part of a proposed 2010 measures group) on which individual eligible professionals can report for the 2010 PQRI. The individual PQRI quality measures proposed for the 2010 PQRI are listed in Tables 17 through 20 and fall into four broad categories as set forth below in this section. The four categories are the following:

(1) Proposed 2010 Individual Quality Measures Selected From the 2009 PQRI Quality Measures Set Available for Claims-based Reporting and Registry-Based Reporting;

(2) Proposed 2010 Individual Quality Measures Selected From the 2009 PQRI Quality Measures Set Available for Registry-based Reporting Only;

(3) New Individual Quality Measures Proposed for 2010; and

(4) Proposed 2010 Measures Available for EHR-based Reporting.

In addition, we propose 13 measures groups for 2010. The measures proposed for inclusion in each of the proposed 2010 measures groups are listed in Tables 21 through 33.

(1) Proposed 2010 Individual Quality Measures Selected From the 2009 PQRI Quality Measures Set Available for Claims-based Reporting and Registry-based Reporting

After careful consideration of 2009 PQRI measures, we propose to retire 7 measures because they did not meet one or more of the considerations for selection of proposed 2010 measures discussed in section II.G.2.h. of this proposed rule. The measures, including their Measure Number and Measure Title, and the specific reason(s) we are using as the basis for our proposal to retire the measures are identified in Table 16.

TABLE 16—2009 PQRI QUALITY MEASURES NOT PROPOSED FOR INCLUSION IN THE 2010 PQRI

Measure no.	Measure title	Reason for retirement
11	Stroke and Stroke Rehabilitation: Carotid Imagining Reporting	Analytically challenging / Replaced with another measure.
34	Stroke and Stroke Rehabilitation: Tissue Plasminogen Activator.	Analytically challenging / Replaced with another measure.
94	Otitis Media with Effusion (OME): Diagnostic Evaluation	Lack of significant reporting.
95	Otitis Media with Effusion (OME): Hearing Test	Lack of significant reporting.
143	Oncology: Medical and Radiation—Pain Intensity Quantified	Analytically challenging.
144	Oncology: Medical and Radiation—Plan of Care for Pain	Analytically challenging.
152	Coronary Artery Disease (CAD): Lipid Profile in Patients with CAD.	Declined for NQF Endorsement.

We propose to include in the 2010 PQRI quality measure set 116 of the 2009 PQRI measures, which would be available for either claims-based reporting or registry-based reporting as individual quality measures. We note that one of these proposed measures, Measure #46 Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility, is reportable through the registry-based reporting mechanism only in the 2009 PQRI. However, for the 2010 PQRI, we propose to make this measure available for either claims-based reporting or registry-based reporting. For the 2009 PQRI, registries have reported difficulty capturing the required information since the measure requires the inpatient discharge to be correlated to the outpatient visit. Therefore, for the 2010 PQRI we propose to make this measure available for both claims-based and registry-based reporting.

These 116 proposed measures do not include any measures that are proposed to be included as part of the 2010 Back Pain measures group. Similar to the 2009 PQRI, we propose that any 2010 PQRI measure that is included in the Back Pain measures group would not be reportable as individual measures through claims-based reporting or registry-based reporting.

The 116 individual 2009 PQRI measures proposed for inclusion in the 2010 PQRI quality measure set as individual quality measures for either claims-based reporting or registry-based reporting are listed by their Measure Number and Title in Table 17, along with the name of the measure's developer/owner, their NQF endorsement status as of May 1, 2009, and their AQA adoption status as of January 31, 2009. The PQRI Measure Number is a unique identifier assigned by CMS to all measures in the PQRI measure set. Once a PQRI Measure Number is assigned to a measure, it will not be used again to identify a different

measure, even if the original measure to which the number was assigned is subsequently retired from the PQRI measure set. A description of the proposed measures listed in Table 17 can be found in the ''2009 PQRI Quality Measures List,'' which is available on the Measures and Codes page of the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI.*

The 2009 measures that are proposed to be available for registry-based reporting only for the 2010 PQRI are discussed and identified in section II.G.2.i.(2) of this proposed rule.

TABLE 17—PROPOSED 2010 MEASURES SELECTED FROM THE 2009 PQRI QUALITY MEASURE SET AVAILABLE FOR EITHER CLAIMS-BASED REPORTING OR REGISTRY-BASED REPORTING

Measure No.	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus.	Yes	Yes	NCQA.
2	Diabetes Mellitus: Low Density Lipoprotein (LDL–C) Control in Diabetes Mellitus.	Yes	Yes	NCQA.
3	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus.	Yes	No	NCQA.
6	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Perscribed for Patients with CAD.	Yes	Yes	AMA–PCPI.
9	Major Depressive Disorder (MDD): Antidepressant Medication During Acute Phase for Patients with MDD.	Yes	Yes	NCQA.
10	Stroke and Stroke Rehabilitation: Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports.	Yes	Yes	AMA–PCPI/NCQA.
12	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation.	Yes	Yes	AMA–PCPI/NCQA.
14	Age-Related macular Degeneration (AMD): Dilated Macular Examination.	Yes	Yes	AMA–PCPI/NCQA.
18	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy.	Yes	Yes	AMA–PCPI/NCQA.
19	Diabetic Retinopathy: Communication with the Physician Managing On-going Diabetes Care.	Yes	Yes	AMA–PCPI/NCQA.
20	Perioperative Care: Timing of Antibiotic Prophylaxis—Ordering Physician.	Yes	Yes	AMA–PCPI/NCQA.
21	Perioperative Care: Selection of Prophylactic Antibiotic—First OR Second Generation Cephalosporin.	Yes	Yes	AMA–PCPI/NCQA.
22	Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures).	Yes	Yes	AMA–PCPI/NCQA.
23	Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients).	Yes	Yes	AMA–PCPI/NCQA.
24	Osteoporosis: Communication with the Physician Managing On-going Care Post Fracture.	Yes	Yes	AMA–PCPI/NCQA.
28	Aspirin at Arrival for Acute Myocardial Infarction (AMI).	Yes	Yes	AMA–PCPI/NCQA.
30	Perioperative Care: Timing of Prophylactic Antibiotics—Administering Physician.	Yes	Yes	AMA–PCPI/NCQA.
31	Stroke and Stroke Rehabilitation: Deep Vein Thrombosis Prophylaxis (DVT) for Ischemic Stroke or Intracranial Hemorrhage.	Yes	Yes	AMA–PCPI/NCQA.
32	Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy.	Yes	Yes	AMA–PCPI/NCQA.
35	Stroke and Stroke Rehabilitation: Screening for Dysphagia.	Yes	Yes	AMA–PCPI/NCQA.
36	Stroke and Stroke Rehabilitation: Consideration for Rehabilitation Services.	Yes	Yes	AMA–PCPI/NCQA.
39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older.	Yes	Yes	AMA–PCPI/NCQA.
40	Osteoporosis: Management Following Fracture.	Yes	Yes	AMA–PCPI/NCQA.
41	Osteoporosis: Pharmacologic Therapy	Yes	Yes	AMA–PCPI/NCQA.
43	Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery.	Yes	Yes	Society of Thoracic Surgeons (STS).

TABLE 17—PROPOSED 2010 MEASURES SELECTED FROM THE 2009 PQRI QUALITY MEASURE SET AVAILABLE FOR EITHER CLAIMS-BASED REPORTING OR REGISTRY-BASED REPORTING—Continued

Measure No.	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
44	Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery.	Yes	Yes	STS.
45	Perioperative Care: Discontinuation of Prophylactic Antiobitics (Cardiac Procedures).	Yes	Yes	AMA–PCPI/NCQA.
46	Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility.	Yes	Yes	AMA–PCPI/NCQA.
47	Advance Care Plan	Yes	Yes	AMA–PCPI/NCQA.
48	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 6 Years and Older.	Yes	Yes	AMA–PCPI/NCQA.
49	Urinary Incontinence: Characterization of Urinary Incontinence in Women Aged 65 Years and Older.	Yes	Yes	AMA–PCPI/NCQA.
50	Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older.	Yes	Yes	AMA–PCPI/NCQA.
51	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation.	Yes	No	AMA–PCPI.
52	Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy.	Yes	No	AMA–PCPI.
53	Asthma: Pharmacologic Therapy	Yes	Yes	AMA–PCPI.
54	12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain.	Yes	Yes	AMA–PCPI/NCQA.
55	12-Lead Electrocardiogram (ECG) Performed for Syncope.	Yes	Yes	AMA–PCPI/NCQA.
56	Community-Acquired Pneumonia (CAP): Vital Signs.	Yes	Yes	AMA–PCPI/NCQA.
57	Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation.	Yes	Yes	AMA–PCPI/NCQA.
58	Community-Acquired Pneumonia (CAP): Assessment of Mental Status.	Yes	Yes	AMA–PCPI/NCQA.
59	Community-Acquired Pneumonia (CAP): Empiric Antibiotic.	Yes	Yes	AMA–PCPI/NCQA.
64	Asthma: Asthma Assessment	Yes	Yes	AMA–PCPI.
65	Treatment for Children with Upper Respiratory Infection (URI): Avoidance of Inappropriate Use.	Yes	Yes	NCQA.
66	Appropriate Testing for Children with Pharyngitis.	Yes	Yes	NCQA.
67	Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow.	Yes	Yes	AMA–PCPI/American Society of Hematology (ASH).
68	Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy.	Yes	Yes	AMA–PCPI/ASH.
69	Multiple Myeloma: Treatment with Bisphosphonates.	Yes	Yes	AMA–PCPI/ASH.
70	Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry.	Yes	Yes	AMA–PCPI/ASH.
71	Breast Cancer: Hormonal Therapy for Stage IC–IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer.	Yes	Yes	AMA–PCPI/American Society of Clinical Oncology (ASCO)/National Comprehensive Cancer Network (NCCN).
72	Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients.	Yes	Yes	AMA–PCPI/ASCO/NCCN.
76	Prevention of Catheter-Related Bloodstream Infections (CRBSI): Central Venous Catheter (CVC) Insertion Protocol.	Yes	Yes	AMA–PCPI.
79	End Stage Renal Disease (ESRD): Influenza Immunization with Patients in ESRD.	Yes	Yes	AMA–PCPI.
84	Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment.	Yes	Yes	AMA–PCPI.
85	Hepatitis C: HCV Genotype Testing Prior to Treatment.	Yes	Yes	AMA–PCPI.
86	Hepatitis C: Antiviral Treatment Prescribed	Yes	Yes	AMA–PCPI.
87	Hepatitis C: HCV Ribonucleic Acid (RNA) Testing at Week 12 of Treatment.	Yes	Yes	AMA–PCPI.
89	Hepatitis C: Counseling Regarding Risk of Alcohol Consumption.	Yes	Yes	AMA–PCPI.

TABLE 17—PROPOSED 2010 MEASURES SELECTED FROM THE 2009 PQRI QUALITY MEASURE SET AVAILABLE FOR EITHER CLAIMS-BASED REPORTING OR REGISTRY-BASED REPORTING—Continued

Measure No.	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
90	Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy.	Yes	Yes	AMA–PCPI.
91	Acute Otitis Externa (ACE): Topical Therapy	No	Yes	AMA–PCPI.
92	Acute Otitis Externa (ACE): Pain Assessment.	No	Yes	AMA–PCPI.
93	Acute Otitis Externa (ACE): Systemic Antimicrobial Therapy—Avoidance of Inappropriate Use.	No	Yes	AMA–PCPI.
99	Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade.	Yes	Yes	AMA–PCPI/College of American Pathologists (CAP).
100	Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grace.	Yes	Yes	AMA–PCPI/CAP.
102	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients.	Yes	Yes	AMA–PCPI.
104	Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Prostate Cancer Patients.	Yes	Yes	AMA–PCPI.
105	Prostate Cancer: Three-Dimensional (3D) Radiotherapy.	Yes	Yes	AMA–PCPI.
106	Major Depressive Disorder (MDD): Diagnostic Evaluation.	Yes	No	AMA–PCPI.
107	Major Depressive Disorder (MDD): Suicide Risk Assessment.	Yes	No	AMA–PCPI.
108	Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy.	Yes	No	NCQA.
109	Osteoarthritis: Function and Pain Assessment.	Yes	No	AMA–PCPI.
110	Preventive Care and Screening: Influenza Immunization for Patients ≥50 Years Old.	Yes	No	AMA–PCPI.
111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older.	Yes	Yes	NCQA.
112	Preventive Care and Screening: Screening Mammography.	Yes	Yes	NCQA.
113	Preventive Care and Screening: Colorectal Cancer Screening.	Yes	Yes	NCQA.
114	Preventive Care and Screening: Inquiry Regarding Tobacco Use.	Yes	Yes	AMA–PCPI.
115	Preventive Care and Screening: Advising Smokers to Quit.	Yes	Yes	NCQA.
116	Antibiotic Treatment for Adults with Acute Bronchitis: Avoidance of Inappropriate Use.	Yes	No	NCQA.
117	Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient.	Yes	Yes	NCQA.
119	Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients.	Yes	No	NCQA.
121	Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorous, Intact Parathyroid Hormone (iPTH) and Lipid Profile).	No	Yes	AMA–PCPI.
122	Chronic Kidney Disease (CKD): Blood Pressure Management.	No	Yes	AMA–PCPI.
123	Chronic Kidney Disease (CKD): Plan of Care—Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA).	No	Yes	AMA–PCPI.
124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR).	Yes	Yes	CMS/Quality Insights of Pennsylvania (QIP).

TABLE 17—PROPOSED 2010 MEASURES SELECTED FROM THE 2009 PQRI QUALITY MEASURE SET AVAILABLE FOR EITHER CLAIMS-BASED REPORTING OR REGISTRY-BASED REPORTING—Continued

Measure No.	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
126	Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy—Neurological Evaluation.	Yes	Yes	American Podiatric Medical Association (APMA).
127	Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention—Evaluation of Footwear.	Yes	Yes	APMA.
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up.	Yes	Yes	CMS/QIP.
130	Documentation and Verification of Current Medications in the Medical Record.	Yes	Yes	CMS/QIP.
131	Pain Assessment Prior to Initiation of Patient Therapy and Follow-Up.	Yes	Yes	CMS/QIP.
134	Screening for Clinical Depression and Follow-Up Plan.	Yes	Yes	CMS/QIP.
135	Chronic Kidney Disease (CKD): Influenza Immunization.	Yes	Yes	AMA–PCPI.
140	Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement.	No	Yes	AMA–PCPI/NCQA.
142	Osteoarthritis (OA): Assessment for Use of Anti-Inflammatory or Analgesic Over-the-Counter (OTC) Medications.	Yes	Yes	AMA–PCPI.
145	Radiology: Exposure Time Reported for Procedures Using Fluoroscopy.	Yes	Yes	AMA–PCPI/NCQA.
146	Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening.	Yes	Yes	AMA–PCPI/NCQA.
147	Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy.	Yes	Yes	AMA–PCPI.
153	Chronic Kidney Disease (CKD): Referral for Arteriovenous (AV) Fistula.	Yes	Yes	AMA–PCPI.
154	Falls: Risk Assessment	No	Yes	AMA–PCPI/NCQA.
155	Falls: Plan of Care	No	Yes	AMA–PCPI/NCQA.
156	Oncology: Radiation Dose Limits to Normal Tissues.	Yes	Yes	AMA–PCPI.
157	Thoracic Surgery: Recording of Clinical Stage for Lung Cancer and Esophageal Cancer Resection.	Yes	Yes	STS.
158	Endarterectomy: Use of Patch During Conventional Endarterectomy.	Yes	No	Society of Vascular Surgeons (SVS).
163	Diabetes Mellitus: Foot Exam	Yes	No	NCQA.
172	Hemodialysis Vascular Access Decision-Making by Surgeon to Maximize Placement of Autogenous Arterial Venous (AV) Fistula.	Yes	No	SVS.
173	Preventive Care and Screening: Unhealthy Alcohol Use—Screening.	No	Yes	AMA–PCPI.
175	Pediatric End Stage Renal Disease (ESRD): Influenza Immunization.	No	Yes	AMA–PCPI.
176	Rheumatoid Arthritis (RA): Tuberculosis Screening.	No	Yes	AMA–PCPI/NCQA.
177	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity.	No	Yes	AMA–PCPI/NCQA.
178	Rhuematoid Arthritis (RA): Functional Status Assessment.	No	Yes	AMA–PCPI/NCQA.
179	Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis.	No	Yes	AMA–PCPI/NCQA.
180	Rheumatoid Arthritis (RA): Glucocorticoid Management.	No	Yes	AMA–PCPI/NCQA.
181	Elder Maltreatment Screen and Follow-Up Plan.	No	Yes	CMS/QIP.
182	Functional Outcome Assessment in Chiropractic Care.	No	Yes	CMS/QIP.
183	Hepatitis C: Hepatitis A Vaccination in Patients with HCV.	Yes	Yes	AMA–PCPI.
184	Hepatitis C: Hepatatis B Vaccination in Patients with HCV.	Yes	Yes	AMA–PCPI.

TABLE 17—PROPOSED 2010 MEASURES SELECTED FROM THE 2009 PQRI QUALITY MEASURE SET AVAILABLE FOR EITHER CLAIMS-BASED REPORTING OR REGISTRY-BASED REPORTING—Continued

Measure No.	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
185	Endoscopy & Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps—Avoidance of Inappropriate Use.	No	Yes	AMA–PCPI/NCQA.
186	Wound Care: Use of Compression System in Patients with Venous Ulcers.	No	Yes	AMA–PCPI/NCQA.

Please note that detailed measure specifications for 2009 individual PQRI quality measures may have been updated or modified during the NQF endorsement process or for other reasons prior to 2010. The 2010 PQRI quality measure specifications for any given individual quality measure may, therefore, be different from specifications for the same quality measure used for 2009. Specifications for all 2010 individual PQRI quality measures, whether or not included in the 2009 PQRI program, must be obtained from the specifications document for 2010 individual PQRI quality measures, which will be available on the PQRI section of the CMS Web site on or before December 31, 2009.

(2) Proposed 2010 Individual Quality Measures Selected From the 2009 PQRI Quality Measures Set Available for Registry-Based Reporting Only

In the 2008 PQRI, all 2008 PQRI quality measures were reportable through either claims-based reporting or registry-based reporting. In the CY 2009 PFS final rule with comment period (73 FR 69833), we noted that some measures are not as conducive to claims-based reporting and indicated that 18 of the 2009 PQRI quality measures are not currently reportable through claims-based reporting due to their complexity. Instead, these 18 measures must be reported through a qualified PQRI registry for the 2009 PQRI. We referred to these measures as ''registry-only'' measures. As discussed further in section II.G.2.d. of this proposed rule, registry-based reporting overcomes some of the limitations of claims-based reporting.

For the 2010 PQRI, we again propose to include registry-only individual measures. For 2010, we propose to select 26 registry-only individual measures from the 2009 PQRI.

As we noted previously, 1 measure (measure #46) that was a registry-only measure for the 2009 PQRI is now proposed to be available for either claims-based reporting or registry-based reporting in the 2010 PQRI. Therefore, this measure is not included among these 26 proposed registry-only individual measures. These 26 proposed measures do include 9 measures that are available for either claims-based reporting or registry-based reporting in the 2009 PQRI and are now proposed to be included in the 2010 PQRI as registry-only measures. We are proposing to make more 2009 measures registry-only to relieve some analytical difficulties encountered during the 2009 PQRI.

Although we are designating certain measures as registry-only measures, we cannot guarantee that there will be a registry qualified to submit each registry-only measure for 2010. We rely on registries to self-nominate and identify the types of measures for which they would like to be qualified to submit quality measures results and numerator and denominator data on quality measures. If no registry self-nominates to submit measure results and numerator and denominator data on a particular type of measure for 2010, then an eligible professional would not be able to report that particular measure type. We invite comments on our proposal to increase the number of registry-only measures for the 2010 PQRI.

The Measure Number and Measure Title for these proposed registry-only measures are listed in Table 18 along with the name of each measure's developer, the measure's NQF endorsement status as of May 1, 2009, and the measure's AQA adoption status as of January 31, 2009. A description of the proposed measures listed in Table 18 can be found in the ''2009 PQRI Quality Measures List,'' which is available on the Measures and Codes page of the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI*. Measures that were available for either claims-based reporting or registry-based reporting in the 2009 PQRI but are proposed to be available for registry-based reporting only in the 2010 PQRI are identified by an asterisk (*) in Table 18.

TABLE 18—PROPOSED 2010 MEASURES SELECTED FROM THE 2009 PQRI QUALITY MEASURE SET AVAILABLE FOR REGISTRY-BASED REPORTING ONLY

Measure No.	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
5	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)*.	Yes	Yes	AMA–PCPI.
7	Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI).	Yes	Yes	AMA–PCPI.
8	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)*.	Yes	Yes	AMA–PCPI.

TABLE 18—PROPOSED 2010 MEASURES SELECTED FROM THE 2009 PQRI QUALITY MEASURE SET AVAILABLE FOR REGISTRY-BASED REPORTING ONLY—Continued

Measure No.	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
33	Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge.	Yes	Yes	AMA–PCPI/NCQA.
81	End Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis in ESRD Patients.	Yes	Yes	AMA–PCPI.
82	End Stage Renal Disease (ESRD): Plan of Care for Inadequate Peritoneal Dialysis.	Yes	Yes	AMA–PCPI.
83	Hepatitis C: Testing for Chronic Hepatitis C—Confirmation of Hepatitis C Viremia*.	Yes	Yes	AMA–PCPI.
118	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LSVD)*.	Yes	No	AMA–PCPI.
136	Melanoma: Follow-Up Aspects of Care*	No	Yes	AMA–PCPI/NCQA.
137	Melanoma: Continuity of Care—Recall System*.	No	Yes	AMA–PCPI/NCQA.
138	Melanoma: Coordination of Care*	No	Yes	AMA–PCPI/NCQA.
139	Cataracts: Comprehensive Preoperative Assessment for Cataract Surgery with Intraocular Lens (IOL) Placement*.	No	Yes	AMA–PCPI/NCQA.
141	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care*.	No	Yes	AMA–PCPI/NCQA.
159	HIV/AIDS: CD4+ Cell Count or CD4+ Percentage.	Yes	No	AMA–PCPI/NCQA.
160	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis.	Yes	No	AMA–PCPI/NCQA.
161	HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy.	Yes	No	AMA–PCPI/NCQA.
162	HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy.	Yes	No	AMA–PCPI/NCQA.
164	Coronary Artery Bypass Graft (CABG): Prolonged Intubation (Ventilation).	Yes	Yes	STS.
165	Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate.	Yes	Yes	STS.
166	Coronary Artery Bypass Graft (CABG): Stroke/Cerebrovascular Accident (CVA).	Yes	Yes	STS.
167	Coronary Artery Bypass Graft (CABG): Postoperative Renal Insufficiency.	Yes	Yes	STS.
168	Coronary Artery Bypass Graft (CABG): Surgical Re-exploration.	Yes	Yes	STS.
169	Coronary Artery Bypass Graft (CABG): Antiplatelet Medications at Discharge.	Yes	Yes	STS.
170	Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge.	Yes	Yes	STS.
171	Coronary Artery Bypass Graft (CABG): Lipid Management and Counseling.	Yes	Yes	STS.
174	Pediatric End Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis.	No	Yes	AMA–PCPI.

* Individual 2009 PQRI measures that were available for both claims-based and registry-based reporting but proposed to be available for registry-based reporting only for the 2010 PQRI.

Please note that detailed measure specifications for 2009 PQRI quality measures may have been updated or modified during the NQF endorsement process or for other reasons prior to 2010. Therefore, the 2010 PQRI quality measure specifications for any given quality measure may be different from specifications for the same quality measure used for 2009. Specifications for all 2010 individual PQRI quality measures, whether or not included in the 2009 PQRI program, must be obtained from the specifications document for 2010 individual PQRI quality measures, which will be available on the PQRI section of the CMS Web site on or before December 31, 2009.

(3) New Individual Quality Measures Proposed for 2010

We propose to include in the 2010 PQRI quality measure set 22 measures that were not included in the 2009 PQRI quality measures provided that each

measure obtains NQF endorsement by July 1, 2009 and its detailed specifications are completed and ready for implementation in PQRI by August 15, 2009. Besides having NQF endorsement, the development of a measure is considered complete for the purposes of the 2010 PQRI if by August 15, 2009—(1) The final, detailed specifications for use in data collection for PQRI have been completed and are ready for implementation, and (2) all of the Category II Current Procedural Terminology (CPT II) codes required for the measure have been established and will be effective for CMS claims data submission on or before January 1, 2010. The titles of these proposed additional, or new, measures are listed in Table 19 along with the name of the measure developer and the proposed reporting mechanism (that is, whether the measure is proposed to be reportable using claims, registries, or both). For these 22 proposed measures, a PQRI Measure Number will be assigned to a measure if and when the measure is included in the final set of 2010 PQRI measures.

Due to the complexity of their measure specifications, we propose that 16 of these 22 measures would be available as registry-only measures for the 2010 PQRI. We do not believe that these 16 measures are conducive to the claims-based reporting mechanism. The remaining 6 measures would be available for reporting through either claims-based reporting or registry-based reporting.

TABLE 19—NEW INDIVIDUAL QUALITY MEASURES PROPOSED FOR 2010

Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer	Reporting mechanism(s)
Thrombolytic Therapy Administered	Yes	No	American Heart Association (AHA)/ American Stroke Association (ASA).	Registry.
Referral for Otologic Evaluation for Patients with Visible Congenital or Traumatic Deformity of the Ear.	Pending NQF review.	No	Audiology Quality Consortium (AQC)	Claims, Registry.
Referral for Otologic Evaluation for Patients with History of Active Drainage from the Ear within the Previous 90 days.	Pending NQF review.	No	AQC	Claims, Registry.
Referral for Otologic Evaluation for Patients with a History of Sudden or Rapidly Progressive Hearing Loss within the Previous 90 days.	Pending NQF review.	No	AQC	Claims, Registry.
Cataracts: 20/40 or Better Visual Acuity within 90 days Following Cataract Surgery.	Pending NQF review.	Yes	American Academy of Ophthalmology (AAO)/AMA–PCPI/NCQA.	Registry.
Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures.	Pending NQF review.	Yes	AAO/AMA–PCPI/NCQA	Registry.
Perioperative Temperature Management.	Yes	Yes	AMA–PCPI	Claims, Registry.
Cancer Stage Documented	Yes	Yes	AMA–PCPI	Claims, Registry.
Stenosis Measurement in Carotid Imaging Studies.	Yes	Yes	American College of Radiology (ACR)/ AMA–PCPI/NCQA.	Claims, Registry.
Coronary Artery Disease (CAD): Symptom and Activity Assessment.	Yes	No	ACC/AHA/AMA–PCPI	Registry.
Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol.	Yes	No	ACC/AHA/AMA–PCPI	Registry.
Heart Failure (HF): Left Ventricular Function Assessment.	Yes	No	ACC/AHA/AMA–PCPI	Registry.
Heart Failure (HF): Patient Education	Yes	No	ACC/AHA/AMA–PCPI	Registry.
Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation.	Yes	No	ACC/AHA/AMA–PCPI	Registry.
Blood Pressure Management: Control	Yes	No	NCQA	Registry.
Complete Lipid Profile	Yes	No	NCQA	Registry.
Cholesterol Count	Yes	No	NCQA	Registry.
Use of Aspirin or Another Anti-Thrombotic.	Yes	No	NCQA	Registry.
HIV/AIDS: Sexually Transmitted Diseases—Chlamydia and Gonorrhea Screenings.	Yes	No	AMA–PCPI/NCQA	Registry.
HIV/AIDS: Screening for High Risk Sexual Behaviors.	Yes	No	AMA–PCPI/NCQA	Registry.
HIV/AIDS: Screening for Injection Drug Use.	Yes	No	AMA–PCPI/NCQA	Registry.
HIV/AIDS: Sexually Transmitted Diseases—Syphilis Screening.	Yes	No	AMA–PCPI/NCQA	Registry.

(4) Proposed 2010 Individual Quality Measures Available for EHR-Based Reporting

As discussed in section II.G.2.d.(3) of this proposed rule, we propose to accept PQRI data from EHRs for a limited subset of the proposed 2010 PQRI quality measures, contingent upon the successful completion of our 2009 EHR data submission testing process and a determination that accepting data from EHRs on quality measures for the 2010 PQRI is practical and feasible. The 10 proposed 2010 PQRI quality measures on which we propose to accept clinical quality data extracted from EHRs are identified in Table 20. We propose to make these measures available for electronic submission via an EHR because these measures target preventive care or common chronic conditions. In addition, 4 of these proposed measures overlap with measures used in the Medicare Quality Improvement Organization program's 9th Statement of Work. Finally, it is much less burdensome for an eligible professional to report Measure #124, which assesses adoption and use of EHRs, through an EHR than through claims.

TABLE 20—PROPOSED 2010 MEASURES AVAILABLE FOR EHR-BASED REPORTING

Measure number	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus.	Yes	Yes	NCQA
2	Diabetes Mellitus: Low Density Lipoprotein (LDL–C) Control in Diabetes Mellitus.	Yes	Yes	NCQA
3	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus.	Yes	No	NCQA
5	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD).	Yes	Yes	AMA–PCPI
7	Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI).	Yes	Yes	AMA–PCPI
110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old.	Yes	No	AMA–PCPI
111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older.	Yes	Yes	NCQA
112	Preventive Care and Screening: Screening Mammography.	Yes	Yes	NCQA
113	Preventive Care and Screening: Colorectal Cancer Screening.	Yes	Yes	NCQA
124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR).	Yes	Yes	CMS/QIP

(5) Measures Proposed for Inclusion in 2010 Measures Groups

We propose to retain the 7 2009 PQRI measures groups for the 2010 PQRI: (1) Diabetes Mellitus; (2) CKD; (3) Preventive Care; (4) CABG; (5) Rheumatoid Arthritis; (6) Perioperative Care; and (7) Back Pain. These measures groups were selected for inclusion in the 2010 PQRI because they each contain at least 4 PQRI quality measures that share a common denominator definition.

Except for the CABG measures group, all 2009 measures groups are reportable either through claims-based reporting or registry-based reporting. The CABG measures group, for the 2009 PQRI, is reportable through the registry-based reporting mechanism only since some measures included in the 2009 CABG measures group are registry-only individual PQRI measures. For this reason, we propose the CABG measures group would be reportable through the registry-based reporting mechanism only for 2010 while the remaining 6 2009 PQRI measures groups would be reportable through either claims-based reporting or registry-based reporting for the 2010 PQRI.

Except for the measures included in the Back Pain measures group, the measures included in a 2009 PQRI measures group are reportable either as individual measures or as part of a measures group. As stated in the CY 2009 PFS final rule with comment period (73 FR 69843 through 69844), as individual measures, the measures in the Back Pain measures group are too basic. However, taken together they are meaningful indicators of quality of care for back pain. For this reason, for the 2010 PQRI, we propose that except for the measures included in the Back Pain measures group, the measures included in a 2009 PQRI measures group that we propose to carry forward for the 2010 PQRI would be reportable either as individual measures or as part of a measures group.

The measures proposed for inclusion in the 2010 measures groups that are based on the measures groups from 2009 are identified in Tables 21 through 27. Some measures proposed for inclusion in some of these measures groups for 2010 were not included in the measures groups in 2009. The 2009 measures proposed for inclusion in a 2010 measures group that were not included in the measures group for 2009 are identified with an asterisk (*).

As with measures group reporting in the 2008 and 2009 PQRI, we propose that each eligible professional electing to report a group of measures for 2010 must report all measures in the group that are applicable to each patient or encounter to which the measures group applies at least up to the minimum number of patients required by applicable reporting criteria (described above in section II.G.2.f. of this proposed rule). The individual measures included in the final 2010 PQRI measures groups will be limited to

those measures which will be identified in the CY 2010 PFS final rule with comment period as final 2010 PQRI measures

TABLE 21—MEASURES PROPOSED FOR 2010 DIABETES MELLITUS MEASURES GROUP

Measure number	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus.	Yes	Yes	NCQA.
2	Diabetes Mellitus: Low Density Lipoprotein (LDL–C) Control in Diabetes Mellitus.	Yes	Yes	NCQA.
3	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus.	Yes	No	NCQA.
117	Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient.	Yes	Yes	NCQA.
119	Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients.	Yes	No	NCQA.
163	Diabetes Mellitus: Foot Exam*	Yes	No	NCQA.

*This 2009 PQRI measure was not part of this measures group for 2009, but is proposed for inclusion in this measures group for 2010.

TABLE 22—MEASURES PROPOSED FOR 2010 CKD MEASURES GROUP

Measure number	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
121	Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile).	No	Yes	AMA–PCPI.
122	Chronic Kidney Disease (CKD): Blood Pressure Management.	No	Yes	AMA–PCPI.
123	Chronic Kidney Disease (CKD): Plan of Care—Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA).	No	Yes	AMA–PCPI.
135	Chronic Kidney Disease (CKD): Influenza Immunization.	No	Yes	AMA–PCPI.
153	Chronic Kidney Disease (CKD): Referral for Arteriovenous (AV) Fistula.	No	Yes	AMA–PCPI.

TABLE 23—MEASURES PROPOSED FOR 2010 PREVENTIVE CARE MEASURES GROUP

Measure number	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older.	Yes	Yes	AMA–PCPI/NCQA.
48	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older.	Yes	Yes	AMA–PCPI/NCQA.
110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old.	Yes	No	AMA–PCPI.
111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older.	Yes	Yes	NCQA.
112	Preventive Care and Screening: Screening Mammography.	Yes	Yes	NCQA.
113	Preventive Care and Screening: Colorectal Cancer Screening.	Yes	Yes	NCQA.
114	Preventive Care and Screening: Inquiry Regarding Tobacco Use.	Yes	Yes	AMA–PCPI.
115	Preventive Care and Screening: Advising Smokers to Quit.	Yes	Yes	NCQA.
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up.	Yes	Yes	CMS/QIP.
173	Preventive Care and Screening: Unhealthy Alcohol Use—Screening*.	No	Yes	AMA–PCPI.

*This 2009 PQRI measure was not part of this measures group for 2009, but is proposed for inclusion in this measures group for 2010.

TABLE 24—MEASURES PROPOSED FOR 2010 CABG MEASURES GROUP [+]

Measure number	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
43	Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery.	Yes	Yes	Society of Thoracic Surgeons (STS).
44	Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery.	Yes	Yes	STS.
164	Coronary Artery Bypass Graft (CABG): Prolonged Intubation (Ventilation).	Yes	Yes	STS.
165	Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate.	Yes	Yes	STS.
166	Coronary Artery Bypass Graft (CABG): Stroke/Cerebrovascular Accident (CVA).	Yes	Yes	STS.
167	Coronary Artery Bypass Graft (CABG): Postoperative Renal Insufficiency.	Yes	Yes	STS.
168	Coronary Artery Bypass Graft (CABG): Surgical Re-exploration.	Yes	Yes	STS.
169	Coronary Artery Bypass Graft (CABG): Antiplatelet Medications at Discharge.	Yes	Yes	STS.
170	Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge.	Yes	Yes	STS.
171	Coronary Artery Bypass Graft (CABG): Lipid Management and Counseling.	Yes	Yes	STS.

[+] This measures group is proposed to be reportable through registry-based reporting only.

TABLE 25—MEASURES PROPOSED FOR 2010 RHEUMATOID ARTHRITIS MEASURES GROUP

Measure number	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
108	Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy.	Yes	No	NCQA.
176	Rheumatoid Arthritis (RA): Tuberculosis Screening.	No	Yes	AMA–PCPI/NCQA.
177	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity.	No	Yes	AMA–PCPI/NCQA.
178	Rheumatoid Arthritis (RA): Functional Status Assessment.	No	Yes	AMA–PCPI/NCQA.
179	Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis.	No	Yes	AMA–PCPI/NCQA.
180	Rheumatoid Arthritis (RA): Glucocorticoid Management.	No	Yes	AMA–PCPI/NCQA.

TABLE 26—MEASURES PROPOSED FOR 2010 PERIOPERATIVE CARE MEASURES GROUP

Measure number	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
20	Perioperative Care: Timing of Antibiotic Prophylaxis—Ordering Physician.	Yes	Yes	AMA–PCPI/NCQA.
21	Perioperative Care: Selection of Prophylactic Antibiotic—First OR Second Generation Cephalosporin.	Yes	Yes	AMA–PCPI/NCQA.
22	Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures).	Yes	Yes	AMA–PCPI/NCQA.
23	Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients).	Yes	Yes	AMA–PCPI/NCQA.

TABLE 27—MEASURES PROPOSED FOR 2010 BACK PAIN MEASURES GROUP

Measure number	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
148	Back Pain: Initial Visit	Yes	Yes	NCQA.
149	Back Pain: Physical Exam	Yes	Yes	NCQA.
150	Back Pain: Advice for Normal Activities	Yes	Yes	NCQA.
151	Back Pain: Advice Against Bed Rest	Yes	Yes	NCQA.

In addition to the 7 measures groups that we propose to retain from the 2009 PQRI, we propose 6 new measures groups for the 2010 PQRI, for a total of 13 CY 2010 measures groups. The 6 new measures groups proposed for the 2010 PQRI are: (1) Coronary Artery Disease (CAD); (2) Heart Failure (HF); (3) Ischemic Vascular Disease (IVD); (4) Hepatitis C; (5) Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS); and (6) Community Acquired Pneumonia (CAP). Many of the 6 new measures groups proposed for 2010 contain proposed new registry-only measures, which would make them reportable through registry-based reporting only. Therefore, only 8 proposed 2010 measures groups would be reportable through either claims-based reporting or registry-based reporting: Diabetes Mellitus; CKD; Preventive Care; Perioperative Care; Rheumatoid Arthritis; Back Pain; Hepatitis C; and Community Acquired Pneumonia. We invite comments on our proposal to limit claims-based reporting of measures groups in 2010.

New measures groups are proposed for the 2010 PQRI in order to address gaps in quality reporting and are those that have a high impact on HHS and CMS priority topics for improved quality and efficiency for Medicare beneficiaries (such as prevention, chronic conditions, high cost/high volume conditions, improved care coordination, improved efficiency, improved patient and family experience of care, and effective management of acute and chronic episodes of care). Groups were identified in topical areas where: (1) 4 or more proposed 2010 measures are available; (2) the measures are NQF endorsed; and (3) they address a gap in quality reporting. The measures proposed for inclusion in these new 2010 measures groups are identified in Tables 28 through 33.

Some measures proposed for inclusion in these 6 measures group are current 2009 individual PQRI measures. The title of each such measure is preceded with its PQRI Measure Number in Tables 28 through 33. As stated previously, the PQRI Measure Number is a unique identifier assigned by CMS to all measures in the PQRI measure set. Once a PQRI Measure Number is assigned to a measure, it will not be used again, even if the measure is subsequently retired from the PQRI measure set. Measures that are not preceded by a number (in other words, those preceded by ''TBD'') in Tables 28 through 33 have never been part of a PQRI measure set until being proposed now. A number will be assigned to such measures if we include them in the final set of 2010 PQRI measures groups.

TABLE 28—MEASURES PROPOSED FOR 2010 CAD MEASURES GROUP +

Measure number	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
6	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD.	Yes	Yes	AMA–PCPI.
114	Preventive Care and Screening: Inquiry Regarding Tobacco Use.	Yes	Yes	AMA–PCPI.
115	Preventive Care and Screening: Advising Smokers to Quit.	Yes	Yes	NCQA.
TBD	Coronary Artery Disease (CAD): Symptom and Activity Assessment.	Yes	Yes	ACC/AHA/AMA–PCPI.
TBD	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol.	Yes	Yes	ACC/AHA/AMA–PCPI.

+ This measures group is proposed to be reportable through registry-based reporting only.

TABLE 29—MEASURES PROPOSED FOR 2010 HF MEASURES GROUP +

Measure number	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
5	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD).	Yes	Yes	AMA–PCPI.
8	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD).	Yes	Yes	AMA–PCPI.
114	Preventive Care and Screening: Inquiry Regarding Tobacco Use.	Yes	Yes	AMA–PCPI.
115	Preventive Care and Screening: Advising Smokers to Quit.	Yes	Yes	NCQA.

TABLE 29—MEASURES PROPOSED FOR 2010 HF MEASURES GROUP [+]—Continued

Measure number	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
TBD	Heart Failure (HF): Left Ventricular Function Assessment.	Yes	Yes	ACC/AHA/AMA–PCPI.
TBD	Heart Failure (HF): Patient Education	Yes	Yes	ACC/AHA/AMA–PCPI.
TBD	Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation.	Yes	Yes	ACC/AHA/AMA–PCPI.

[+] This measures group is proposed to be reportable through registry-based reporting only.

TABLE 30—MEASURES PROPOSED FOR 2010 IVD MEASURES GROUP [+]

Measure number	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure Developer
114	Preventive Care and Screening: Inquiry Regarding Tobacco Use.	Yes	Yes	AMA–PCPI.
115	Preventive Care and Screening: Advising Smokers to Quit.	Yes	Yes	NCQA.
TBD	Blood Pressure Management: Control	Yes	No	NCQA.
TBD	Complete Lipid Profile	Yes	No	NCQA.
TBD	Cholesterol Control	Yes	No	NCQA.
TBD	Use of Aspirin or Another Anti-Thrombotic	Yes	No	NCQA.

[+] This measures group is proposed to be reportable through registry-based reporting only.

TABLE 31—MEASURES PROPOSED FOR 2010 HEPATITIS C MEASURES GROUP

Measure No.	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
84	Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment.	Yes	Yes	AMA–PCPI.
85	Hepatitis C: HCV Genotype Testing Prior to Treatment.	Yes	Yes	AMA–PCPI.
86	Hepatitis C: Antiviral Treatment Prescribed	Yes	Yes	AMA–PCPI.
87	Hepatitis C: HCV Ribonucleic Acid (RNA) Testing at Week 12 of Treatment.	Yes	Yes	AMA–PCPI.
89	Hepatitis C: Counseling Regarding Risk of Alcohol Consumption.	Yes	Yes	AMA–PCPI.
90	Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy.	Yes	Yes	AMA–PCPI.
183	Hepatitis C: Hepatitis A Vaccination in Patients with HCV.	Yes	Yes	AMA–PCPI.
184	Hepatitis C: Hepatitis B Vaccination in Patients with HCV.	Yes	Yes	AMA–PCPI.

TABLE 32—MEASURES PROPOSED FOR 2010 HIV/AIDS MEASURES GROUP [+]

Measure No.	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
159	HIV/AIDS: CD4+ Cell Count or CD4+ Percentage.	Yes	No	AMA–PCPI/NCQA.
160	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis.	Yes	No	AMA–PCPI/NCQA.
161	HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy.	Yes	No	AMA–PCPI/NCQA.
162	HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy.	Yes	Yes	AMA–PCPI/NCQA.
TBD	HIV/AIDS: Sexually Transmitted Diseases—Chlamydia and Gonorrhea Screenings.	Yes	Yes	AMA–PCPI/NCQA.
TBD	HIV/AIDS: Screening for High Risk Sexual Behaviors.	Yes	Yes	AMA–PCPI/NCQA.
TBD	HIV/AIDS: Screening for Injection Drug Use	Yes	Yes	AMA–PCPI/NCQA.

TABLE 32—MEASURES PROPOSED FOR 2010 HIV/AIDS MEASURES GROUP +—Continued

Measure No.	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
TBD	HIV/AIDS: Sexually Transmitted Diseases—Syphilis Screening.	Yes	No	AMA–PCPI/NCQA.

+ This measures group is proposed to be reportable through registry-based reporting only.

TABLE 33—MEASURES PROPOSED FOR 2010 COMMUNITY-ACQUIRED PNEUMONIA MEASURES GROUP

Measure No.	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
56	Community-Acquired Pneumonia (CAP): Vital Signs.	Yes	Yes	AMA–PCPI/NCQA.
57	Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation.	Yes	Yes	AMA–PCPI/NCQA.
58	Community-Acquired Pneumonia (CAP): Assessment of Mental Status.	Yes	Yes	AMA–PCPI/NCQA.
59	Community-Acquired Pneumonia (CAP): Empiric Antibiotic.	Yes	Yes	AMA–PCPI/NCQA.

We note that the specifications for measures groups do not necessarily contain all the specification elements of each individual measure making up the measures group. This is based on the need for a common set of denominator specifications for all the measures making up a measures group in order to define the applicability of the measures group. Therefore, the specifications and instructions for measures groups will be provided separately from the specifications and instructions for the individual 2010 PQRI measures. We will post the detailed specifications and specific instructions for reporting measures groups on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI* by no later than December 31, 2008.

Additionally, the detailed measure specifications and instructions for submitting data on those proposed 2010 measures groups that were also included as 2009 PQRI measures groups may be updated or modified prior to 2010. Therefore, the 2010 PQRI measure specifications for any given measures group could be different from specifications and submission instructions for the same measures group used for 2009. These measure specification changes do not materially impact the intended meaning of the measures or the strength of the measures.

(6) Request for Public Comment on Measure Suggestions for Future PQRI Quality Measure Sets

As stated above, on February 1, 2009, we posted a ''Call for 2010 PQRI Measure Suggestions'' on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI*. The ''Call for 2010 PQRI Measure Suggestions'' invited the public to submit suggestions for individual quality measures and measures groups (that is, suggestions for new measures groups and/or suggestions for the composition of existing measures groups) for consideration for possible inclusion in the proposed set of quality measure for use in the 2010 PQRI. To facilitate our evaluation of the suggested measures, we asked individuals or organizations submitting suggestions to provide us with the following information:

- Requestor contact information, such as name and title, organization/practice name, phone number and e-mail address;
- Measure title;
- Measure description;
- Measure owner/developer;
- NQF endorsement status, including the date of endorsement or anticipated endorsement (if not NQF-endorsed) and type of endorsement (for example, time-limited endorsement);
- AQA adoption status, including date of AQA adoption or anticipated AQA adoption;
- Preferred PQRI reporting option for the suggested measure(s) (that is, claims, registry, registry-only, measures group, measures group only, EHRs); and
- The measure specifications.

In lieu of posting a call for 2011 PQRI measure suggestions on the PQRI section of the CMS Web site in 2010, we invite commenters to submit suggestions for individual quality measures and measures groups (that is, suggestions for new measures groups and/or suggestions for the composition of proposed 2010 measures groups) for consideration for possible inclusion in the proposed set of quality measures for use in the 2011 PQRI. When submitting suggestions for future PQRI quality measure sets as part of the comment period for this proposed rule, commenters should submit all the information requested above for the ''Call for 2010 PQRI Measure Suggestions.''

Please note that suggesting individual measures or measures for a new or proposed measures group does not mean that the measure(s) will be included in the proposed or final sets of measures of any proposed or final rules that address the 2011 PQRI. We will determine what individual measures and measures group(s) to include in the proposed set of quality measures, and after a period of public comment, we will make the final determination with regard to the final set of quality measures for the 2011 PQRI.

j. Proposed 2010 PQRI Quality Measures for Physician Groups Selected to Participate in the Group Practice Reporting Option

As discussed in section II.G.2.g. of this proposed rule, we propose that physician groups selected to participate in the 2010 PQRI group practice reporting option would be required to report on 26 measures. These measures are NQF-endorsed measures currently collected as part of the PGP and/or MCMP demonstrations and are identified in Table 34. To the extent that a measure is an existing PQRI measure, the Measure Title is preceded by the measure's PQRI Measure Number. If there is no number in the Measure Number column of the table, then the

measure is not an existing PQRI measure and will be added to the 2010 PQRI for purposes of the group practice reporting option.

TABLE 34—MEASURES PROPOSED FOR PHYSICIAN GROUPS PARTICIPATING IN THE 2010 PQRI GROUP PRACTICE REPORTING OPTION

Measure No.	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
1	Diabetes Mellitus: Hemoglobin A1c Poor Control.	Yes	Yes	NCQA.
2	Diabetes Mellitus: Low Density Lipoprotein Control.	Yes	Yes	NCQA.
3	Diabetes Mellitus: High Blood Pressure Control.	Yes	No	NCQA.
5	Heart Failure: ACE Inhibitor or ARB Therapy for LVSD.	Yes	Yes	AMA–PCPI.
6	Coronary Artery Disease: Oral Anti-platelet Therapy.	Yes	Yes	AMA–PCPI.
7	Coronary Artery Disease:Beta-blocker Therapy for CAD Patients with Prior MI.	Yes	Yes	AMA–PCPI.
8	Heart Failure: Beta-blocker Therapy for LVSD.	Yes	Yes	AMA–PCPI.
110	Preventive Care: Influenza Vaccination for Patients > 50 years.	Yes	No	AMA–PCPI.
111	Preventive Care: Pneumonia Vaccination for Patients 65+ years.	Yes	Yes	NCQA.
112	Preventive Care: Screening Mammography	Yes	Yes	NCQA.
113	Preventive Care: Screening Colorectal Cancer.	Yes	Yes	NCQA/AMA–PCPI.
117	Diabetes Mellitus: Dilated Eye Exam	Yes	Yes	NCQA.
118	Coronary Artery Disease: ACE/ARB for Patients with CAD and Diabetes and/or LVSD.	Yes	No	AMA–PCPI.
119	Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy.	Yes	No	NCQA.
163	Diabetes Mellitus: Foot Exam	Yes	No	NCQA.
TBD	Diabetes Mellitus: Hemoglobin A1c Testing	Yes	No	NCQA.
TBD	Diabetes Mellitus: Lipid Profile	Yes	No	NCQA.
TBD	Heart Failure: Left Ventricular Function Testing.	Yes	Yes	CMS.
TBD	Heart Failure: Left Ventricular Function Assessment.	Yes	Yes	ACC/AHA/AMA–PCPI.
TBD	Heart Failure: Weight Measurement	Yes	No	ACC/AHA/AMA–PCPI.
TBD	Heart Failure: Patient Education	Yes	Yes	ACC/AHA/AMA–PCPI.
TBD	Heart Failure: Warfarin Therapy for Patients with Atrial Fibrillation.	Yes	Yes	ACC/AHA/AMA–PCPI.
TBD	Coronary Artery Disease: Drug Therapy for Lowering LDL-Cholesterol.	Yes	Yes	ACC/AHA/AMA–PCPI.
TBD	Preventive Care: Blood Pressure Management.	Yes	No	ACC/AHA/AMA–PCPI.
TBD	Hypertension: Blood Pressure Control	Yes	No	CMS/NCQA.
TBD	Hypertension: Plan of Care	Yes	No	ACC/AHA/AMA–PCPI.

k. Public Reporting of PQRI Data

Section 1848(m)(5)(G) of the Act, as added by the MIPPA, requires the Secretary to post on the CMS Web site, in an easily understandable format, a list of the names of eligible professionals (or group practices) who satisfactorily submitted data on quality measures for the PQRI and the names of the eligible professionals (or group practices) who are successful electronic prescribers as defined and discussed further in section II.G.5. of this proposed rule. In accordance with section 1848(m)(5)(G) of the Act, we indicated in the CY 2009 PFS final rule with comment period (73 FR 69846 through 69847) our intent, in 2010, to enhance the current Physician and Other Health Care Professionals directory at *http://www.medicare.gov* with the names of eligible professionals that satisfactorily submit quality data for the 2009 PQRI. In December 2008, we listed, by State, the names of eligible professionals who participated in the 2007 PQRI on the Physician and Other Health Care Professionals Directory.

As required by section 1848(m)(5)(G) of the Act, we intend to make public the names of eligible professionals and group practices that satisfactorily submit quality data for the 2010 PQRI on the Physician and Other Health Care Professionals Directory. We anticipate that the names of individual eligible professionals and group practices that satisfactorily submit quality data for the 2010 PQRI will be available in 2011 after the 2010 incentive payments are paid.

For purposes of publicly reporting the names of eligible professionals, on the Physician and Other Health Care Professionals Directory, we propose to post the names of eligible professionals who: (1) Submit data on the 2010 PQRI quality measures through one of the

reporting mechanisms available for the 2010 PQRI; (2) meet one of the proposed satisfactory reporting criteria of individual measures or measures groups for the 2010 PQRI described above in section II.G.2.e. and II.G.2.f., respectively of this proposed rule; and (3) qualify to earn a PQRI incentive payment for covered professional services furnished during the applicable 2010 PQRI reporting period.

Similarly, for purposes of publicly reporting the names of group practices, on the Physician and Other Health Care Professionals Directory, we propose to post the names of group practices who: (1) Submit data on the 2010 PQRI quality measures through the proposed group practice reporting option described in section II.G.2.g. of this proposed rule; (2) meet the proposed criteria for satisfactory reporting under the group practice reporting option; and (3) qualify to earn a PQRI incentive payment for covered professional services furnished during the applicable 2010 PQRI reporting period for group practices.

In addition to posting the information required by section 1848(m)(5)(G) of the Act, for those group practices that are selected to participate in PQRI under the group practice reporting option, we also propose to make the group practices' PQRI performance rates publicly available, for each of the measures. As we stated in the CY 2009 PFS proposed rule (73 FR 38574 through 38575), it is our goal to make the quality of care for services furnished to Medicare beneficiaries publicly available by making physician quality measure performance rates, either at the individual practitioner level or physician group level, publicly available. While we currently have Web pages at *http://www.medicare.gov* for the public reporting of performance results on standardized quality measures for hospitals (Hospital Compare), dialysis facilities (Dialysis Facility Compare), nursing homes (Nursing Home Compare), and home health facilities (Home Health Compare), we do not have a similar Compare Web site for information on the quality of care for services furnished by physicians and other professionals to Medicare beneficiaries.

Public reporting of group practices' PQRI performance results at the group practice level would allow us to move toward our goal of making information on physician performance publicly available. We believe that the way we have proposed to design the group practice reporting option (*see* section II.G.2.g. of this proposed rule) facilitates public reporting of the groups' performance results. Group practices participating in the group practice reporting option would have already agreed in advance to have their performance results publicly reported. All groups participating in the group practice reporting option would be reporting on identical measures, which facilitate comparison of the results across groups. In addition, as a result of the proposed reporting criteria, no performance results would be calculated based on small denominator sizes. Finally, because we intend to modify the data collection tool will provide each group practice with numerator, denominator, and performance rates for each measure at the time of tool submission, the group practice will have had an opportunity to review their performance results before they are made public.

In making performance rates for group practices publicly available, we will attribute the group practice's performance to the entire group. We will not post information with respect to the performance of individual physicians or other eligible professionals associated with the group. However, we may identify the individual eligible professionals who were associated with the group during the reporting period. We invite comments regarding our proposal to publicly report group practices' PQRI performance results.

3. Section 131(c): Physician Resource Use Measurement and Reporting Program

a. Statutory Authority

As required under section 1848(n) of the Act, as added by section 131(c) of the MIPPA, we established and implemented by January 1, 2009, a Physician Feedback Program using Medicare claims data and other data to provide confidential feedback reports to physicians (and as determined appropriate by the Secretary, to groups of physicians) that measure the resources involved in furnishing care to Medicare beneficiaries. Section 1848(n) of the Act authorizes us, as we determine appropriate, to include information on the quality of care furnished to Medicare beneficiaries by the physician (or group of physicians) in the reports. Although we initially called this effort the Physician Resource Use Feedback Program, we are renaming this initiative the ''Physician Resource Use Measurement and Reporting Program'' (hereinafter referred to as ''Program'').

b. Background

As we stated in the CY 2009 PFS final rule with comment period (73 FR 69866), the Program would consist of multiple phases. We included a summary of the activities of phase I of the Program in the CY 2009 PFS final rule with comment period (73 FR 69866 through 69869). In addition to discussing phase I of the Program, we also highlighted the activities of several other initiatives, including Medicare Value-Based Purchasing (VBP) programs and demonstrations and related activities undertaken by the MedPAC and the Government Accountability Office (GAO). We refer readers to the CY 2009 PFS final rule with comment period (73 FR 69866 through 69869) for a detailed discussion of these activities.

In the CY 2009 PFS final rule with comment period (73 FR 69866 through 69869), we finalized, on an interim basis, the following parameters for phase I of the Program: (1) Use of both per capita and episode of care methodologies for resource use measurement; (2) cost of service category analysis (for example, imaging services or inpatient admissions); (3) use of 4 calendar years of claims data; (4) focus on high cost and/or high volume conditions; (5) reporting to physician specialties relevant to the selected focal conditions; (6) focus on physicians practicing in certain geographic areas, and (7) low, median, and high cost benchmarks. We intend to finalize these parameters in the CY 2010 PFS final rule with comment period.

c. Summary of Comments From the CY 2009 PFS Final Rule With Comment Period

Section 1848(n)(1)(B) of the Act requires that the Program measures resources based on the following: (1) An episode basis; (2) a per capita basis; or (3) both an episode and a per capita basis. We solicited public comments on the use of each of these measurement methodologies (73 FR 69868).

Comment: Commenters were in favor of using both the per capita and the per episode measurement methodologies.

Response: We agree with commenters that both the per capita and per episode methodologies are appropriate measures of cost for the Program. Each methodology offers distinct advantages. For a further discussion regarding the advantages, we refer readers to CMS' Medicare Resource Use Measurement Plan Web site at *http://www.cms.hhs.gov/QualityInitiativesGenInfo/downloads/ResourceUse_Roadmap_OEA_1–15_508.pdf*. We intend to finalize both

methodologies as options for use in future phases of the Program in the CY 2010 PFS final rule with comment period.

In phase I of the Program, we included cost of service (COS) category information from aggregated Medicare FFS claims data. We solicited public comment on which COS categories are most meaningful and actionable (73 FR 69868).

Comment: Commenters were overwhelmingly in favor of including E/M services and imaging services as meaningful and actionable COS categories. Further, commenters supported including laboratory services, outpatient services, procedures, and post-acute services as COS categories. No commenters raised specific categories that should be excluded.

Response: We appreciate the comments in support of the COS category analysis. We intend to finalize the option to include information on all of these COS categories in future phases of the Program in the CY 2010 PFS final rule with comment period.

Section 1848(n)(3) of the Act requires that, to the extent practicable, the data for the reports shall be based on the most recent data available. In phase I of the Physician Resource Use Feedback Program, we used Medicare FFS claims data from CY 2004 through CY 2007. We solicited public comment on this approach (73 FR 69868).

Comment: The majority of commenters stated that 3 calendar years of data is sufficient for calculating resource use measures. Further, commenters emphasized, to the extent practicable, CMS should use the most recent three years of data available for the Program.

Response: We agree with commenters that 3 years of Medicare FFS claims data are sufficient for calculating resource use measures. We intend to finalize the use of the most recent 3 years of data available for the Program in the CY 2010 PFS final rule with comment period.

Under section 1848(n)(4)(B) of the Act, the Secretary may focus the Program as appropriate, including focusing on physicians who treat conditions that are high cost, high volume, or both. We finalized on an interim basis for phase I of the Program, the following conditions: (1) Congestive heart failure; (2) chronic obstructive pulmonary disease; (3) prostate cancer; (4) cholecystitis; (5) coronary artery disease with acute myocardial infarction; (6) hip fracture; (7) community-acquired pneumonia; and (8) urinary tract infection (73 FR 69868). We solicited public comments on the use of these high cost/high volume conditions (73 FR 69868).

Comment: Commenters strongly supported these conditions as appropriate for measuring the resources furnished to Medicare beneficiaries. In addition, several commenters suggested that we include diabetes among the priority conditions for the Program.

Response: We agree with commenters that diabetes is an important condition to capture in the Program. We intend to finalize the option to include: (1) Congestive heart failure; (2) chronic obstructive pulmonary disease; (3) prostate cancer; (4) cholecystitis; (5) coronary artery disease with acute myocardial infarction; (6) hip fracture; (7) community-acquired pneumonia; (8) urinary tract infection; and (9) diabetes, in the Program in the CY 2010 PFS final rule with comment period.

Under section 1848(n)(4)(A) of the Act, we are permitted to focus reporting on physician specialties that account for a certain percentage of spending for physicians' services. Based on the high cost and high volume conditions selected above, we included the following physician specialties in phase I of the Program: General internal medicine, family practice, gastroenterology, cardiology, general surgery, infectious disease, neurology, orthopedic surgery, physical medicine and rehabilitation, pulmonology, and urology (73 FR 69868). We solicited public comments on the inclusion of these physician specialties (73 FR 69868).

Comment: Commenters supported including all of the physician specialties listed above as appropriate for measurement and reporting based on the selected conditions.

Response: We agree with commenters that the physician specialties listed above should be included in the Program. We intend to finalize the option to include these physician specialties in the Program in the CY 2010 PFS final rule with comment period.

Section 1848(n)(4)(D) of the Act permits us to focus the Program on physicians practicing in certain geographic areas. In the CY 2009 PFS final rule with comment period (73 FR 69866 through 69869) we referenced two geographic sites (Baltimore, MD and Boston, MA) for phase I of the Program, which we generally selected based on close proximity to the CMS central office and due to high per capita Medicare costs, respectively. Since the final rule was published, we have also mailed reports to physicians in the following sites:

- Greenville, SC;
- Indianapolis, IN;
- Northern New Jersey;
- Orange County, CA;
- Seattle, WA;
- Syracuse, NY;
- Boston, MA;
- Cleveland, OH;
- East Lansing, MI;
- Little Rock, AR;
- Miami, FL; and
- Phoenix, AZ.

Comment: Commenters were in favor of including a limited number of sites representing a wide range of geographic locations to facilitate a phased implementation. No commenters submitted specific areas that should be excluded.

Response: We appreciate the comments in support of including a limited number of sites. We intend to continue to include the geographic sites listed above, and identify a limited number of new locations, in the Program in the CY 2010 PFS final rule with comment period.

Section 1848(n)(4)(C) of the Act also permits us to focus the program on physicians who use a high amount of resources compared to other physicians. The resource use reports disseminated in phase I of the Program defined peer groups of physicians by focusing on one condition, one specialty, and one of the geographic locations mentioned above. Within each peer group, the resource use reports indicated whether the physician fell over the 90th percentile (high cost benchmark), below the 10th percentile (low cost benchmark), or over the 50th percentile (median cost benchmark). We solicited public comments on which cost benchmarks make the resource use reports meaningful, actionable, and fair (73 FR 69869).

Comment: Commenters supported the use of high, median, and low cost benchmarks because the benchmarks highlight useful cost categories within a given peer group.

Response: We agree with commenters that the high, median, and low cost benchmarks are appropriate. We intend to finalize these cost benchmarks as options to include in the Program in the CY 2010 PFS final rule with comment period.

Comment: A few commenters expressed support for including small geographic areas for benchmarking.

Response: Though we recognize that a small geographic benchmark may capture a more homogenous beneficiary population for comparison, smaller sample sizes may adversely affect the statistical precision of the comparison. A larger sample captured through broader geographic benchmarks makes

it less likely that physicians will be erroneously identified as high or low cost outliers.

In addition to commenting on specific statutory parameters, commenters also provided feedback on other general topics. Those comments and responses are included below.

Comment: A few commenters mentioned the use of proprietary commercial episode grouper software as a barrier to transparency within the Program. These commenters indicated that in order to understand and validate the resource use reports, physicians would need additional information about how the proprietary commercial software allocated costs to episodes.

Response: One of the primary goals of CMS' VBP initiatives is to implement performance-based incentive payment programs with transparent methodologies. We note that the Program is currently limited under section 1848(n)(1)(A) of the Act to confidential reporting. Use of physician resource use information for other purposes, such as payment or public reporting, would likely require a higher level of transparency than confidential reporting.

We note that we have previously discussed the use of proprietary products for payment purposes in previous rules published in the **Federal Register**. For example, we discussed the use of a proprietary product prior to implementation of the MS–DRGs in the FY 2007 IPPS final rule (72 FR 47171).

We recognize the efforts of episode grouper vendors toward improved transparency. For more information on episode groupers that is publicly available, we refer readers to the following Web sites: *http://www.ingenix.com/ThoughtLeadership/ETG/EtgRegistration/* and *http://www.thomsonreuters.com/business_units/healthcare/*.

We are soliciting public comment on the use of proprietary products to measure episodes of the care in the Program.

Comment: Some commenters expressed that the best method for dissemination of resource use reports is paper copies distributed via the mail. Others favored an electronic mechanism for dissemination. Some commenters expressed that resource use reports should be made available in both paper format and electronically.

Response: For phase I of the Program, we disseminated reports in paper form via mail. We agree with commenters that electronic dissemination would also be desirable. Pending resource availability, we will consider this suggestion in a future phase of the Program.

d. Phase I of the Program

As indicated above, the Program consists of multiple phases. Under this approach, each phase of the Program will inform future phases of the Program. We refer readers to the CY 2009 PFS final rule with comment period (73 FR 69866 through 69869) for a description of phase I Program activities. Using the parameters that were finalized on an interim basis, we have disseminated approximately 230 resource use reports to physicians in each of the 12 geographic regions listed above in this section. We refer readers to the following Web site to review a de-identified sample of the resource use reports disseminated to physicians: *http://rurinfo.mathematica-mpr.com/*. We are soliciting public comment on the design and elements of the sample resource use report used in phase I of the Program. We are particularly interested in receiving comment on the usefulness of the cost of service category drill-down analysis included on pages 10, 16, 20, 24, 28, 32, and 36 of the sample resource use report. These comments will inform future phases of the Program.

e. Phase II of the Program

For phase II, we are proposing to expand the Program in ways that will make the information more meaningful and actionable for physicians. We are proposing to add reporting to groups of physicians recognizing that physicians practice in various arrangements. Group level reporting provides a mechanism for addressing sample size issues that arise when individual physicians have too few Medicare beneficiaries with specific conditions to generate statistically significant reports. We are also proposing to add quality measurement information as context for interpreting comparative resource use. These proposals are addressed in greater detail below in this section.

Phase I of the Program focused on providing confidential feedback on resource use measures to individual physicians. Section 1848(n)(1)(A) of the Act states that the Secretary may also provide confidential feedback reports to groups of physicians. Many physicians practice in groups. Recognizing groups of physicians within the Program is consistent with other CMS VBP initiatives and demonstrations under the Medicare program.

We are proposing to provide reports to groups of physicians, in addition to providing reports to individual physicians, for the Program. In December 2008, CMS posted an Issues Paper on the Development of a Transition to a Medicare Physician Value-Based Purchasing Program for Physician and Other Professional Services.[1] The Issues paper describes cost of care measurement, the focus of Phase I of this Program, as one of the central tenets of Physician Value-Based Purchasing (*see* section II.G.4. of this proposed rule). Further, the Issues Paper referenced possible groups of physicians under consideration including: (1) Formally established single or multi-specialty group practices; (2) physicians practicing in defined geographic regions; and (3) physicians practicing within facilities or larger systems of care. We are soliciting public comments on the appropriateness of resource use measurement and reporting for these and other groups of physicians.

Phase I of the Program focused on providing confidential feedback on resource use measures. Section 1848(n)(1)(A) of the Act states that the Secretary may also include information on quality of care furnished to Medicare beneficiaries by the physician. Providing physicians with feedback on both quality and cost of care better captures the value of the care provided. Including quality measures in the Program is consistent with the direction for other CMS VBP initiatives.

We are proposing the use of quality measures, in addition to resource use measures, for the Program. Possible sources of quality measures include the Physician Quality Reporting Initiative (PQRI) (*see* section II.G.2. of this proposed rule) and the Generating Medicare Physician Quality Performance Measurement Results (referred to as GEM) Project.[2] We refer readers to the Issues Paper, mentioned above,[3] for additional discussion on how CMS would use quality measures in this Program and for Physician Value-Based Purchasing (*see* section II.G.4. of this proposed rule). We are soliciting public comments on the use of PQRI, GEM, and other broader aggregate quality measures to be used to capture value for the groups proposed above in the Physician Resource Use Measurement and Reporting Program.

[1] *http://www.cms.hhs.gov/PhysicianFeeSched/downloads/PhysicianVBP-Plan-Issues-Pape.pdf.*

[2] *http://www.cms.hhs.gov/GEM/.*

[3] *http://www.cms.hhs.gov/PhysicianFeeSched/downloads/PhysicianVBP-Plan-Issues-Pape.pdf.*

4. Section 131(d): Plan for Transition to Value-Based Purchasing Program for Physicians and Other Practitioners

a. Background

Value-based purchasing uses payment incentives and transparency to increase the value of care by rewarding providers for higher quality and more efficient services and for publicly reporting performance information. Section 131(d) of the MIPPA requires the Secretary to develop a plan to transition to a value-based purchasing (VBP) program for Medicare payment for covered professional services made under, or based on, the PFS. Section 131(d) of the MIPPA also states that by May 1, 2010, the Secretary shall submit a report to the Congress, containing the plan, together with recommendations for such legislation and administrative action as the Secretary determines appropriate. The Secretary, through the Physician and Other Health Professional VBP (PVBP) Workgroup, submitted a progress letter to Congress on January 8, 2009 detailing the progress made on the VBP plan for physicians and other professionals.

Currently, Medicare health professional payments are based on quantity of services and procedures provided, without recognition of quality or efficiency. Under various authorities, we have pursued the implementation of building blocks to support the establishment of a VBP program for health professionals. These include initiatives in the following major topic areas: Quality and efficiency measurement and reporting, approaches for aligning incentives with providing higher quality care instead of higher volume of care, care coordination, prevention, and health information technology (HIT). The following is a list of examples of the initiatives specifically relevant to physicians and other health professionals:

- Pay for reporting of quality measurement data instituted under the Physician Quality Reporting Initiative (PQRI);
- Resource use reports comparing overall costs, as well as costs for treatment across episodes of care, as part of, as required by the Physician Resource Use Feedback Program (*See* section II.G.3. of this proposed rule); and
- Demonstration projects, including the Physician Group Practice demonstration of a shared savings model, gainsharing demonstrations, medical home and other care coordination and disease management demonstrations, and the Acute Care Episodes demonstration of a bundled payment model.

We are fully committed to implementing VBP incentives to drive quality improvement and greater efficiency for services furnished to Medicare beneficiaries.

b. Approach to Plan Development

We have created an internal cross-component team, the PVBP Workgroup, to lead development of the PVBP Plan. Four Subgroups were established to address the major sections of the Plan: Measures; incentives; data strategy and infrastructure; and public reporting. The PVBP Workgroup was tasked with reviewing the state-of-the-art in performance-based payment for physicians, including relevant Medicare programs and demonstrations and private sector initiatives; preparing an Issues Paper to present program objectives and design principles; engaging stakeholders and obtaining input on program design; and developing the PVBP Plan and Report to Congress. A similar approach was used in the development of the CMS Hospital VBP Plan.

To guide the planning process, the PVBP Workgroup adopted the following goal to improve Medicare beneficiary health outcomes and experience of care by using payment incentives and transparency to encourage higher quality, more efficient professional services. In pursuit of this goal, the Workgroup has defined the following objectives:

- Promote evidence-based medicine through measurement, payment incentives, and transparency.
- Reduce fragmentation and duplication through accountability across settings, alignment of measures and incentives across settings, better care coordination for smoother transitions, and attention to episodes of care.
- Encourage effective management of chronic disease by improving early detection and prevention, focusing on preventable hospital readmissions, and emphasizing the importance of advanced care planning and appropriate end-of-life care.
- Accelerate the adoption of effective, interoperable HIT, including clinical registries, e-prescribing, and electronic health records.
- Empower consumers to make value-based health care choices and encourage health professionals to improve the value of care by disseminating actionable performance information.

The goal and objectives were captured in an Issues Paper that was posted on the CMS Web site on November 24, 2008, in preparation for the December 9, 2008 Listening Session which was held at CMS headquarters. The Issues Paper included questions seeking public input on key design considerations. The Issues Paper is available on the CMS Web site at *http://www.cms.hhs.gov/PhysicianFeeSched/downloads/PhysicianVBP-Plan-Issues-Paper.pdf*. Nearly 500 stakeholders participated in the day-long Listening Session. We received both verbal and written comments that are informing the design of the PVBP Plan.

c. Stakeholder Input From the Listening Session

Both at the Listening Session, and in written comments received following the Session, we obtained input from a wide range of diverse stakeholders. A large portion of the comments were received from physician and other professional specialty societies. Commenters also included consumer advocates, health care consulting firms, and health IT vendors, and individual practicing physicians.

(1) Overarching Issues

Commenters generally affirmed the goal and objectives presented in the Issues Paper. Commenters encouraged the consideration of new payment approaches that cut across settings of care to align Medicare Part A and Part B payment incentives. Many commenters stated that the current Medicare payment system for health professionals is flawed in that it fails to align incentives for high-value care across providers and settings and that this cannot be fixed solely by a VBP program. Commenters agreed with the Issues Paper assumption that the Plan will need to contain more than one approach to accommodate different practice arrangements. Several commenters praised the attention given in the Issues Paper to addressing disparities and pointed out the necessity of adequate risk adjustment and proper use of measures, incentives, and program evaluation to protect vulnerable populations. Commenters also urged careful attention to the operational transition from the current payment system to VBP to minimize care delivery disruptions.

(2) Measurement

Commenters emphasized the importance of aligning measures across payment settings and applying measures consistently across payers. Many commenters stressed the need for valid, reliable, nationally-recognized measures, particularly in the areas of outcomes, care coordination, patient

experience, and the effective use of HIT. Adequate risk adjustment was raised as a paramount issue for outcomes and resource use measures. Regarding resource use measures, several commenters noted that quality and cost measures should be reported together and that CMS should get experience with confidential feedback reporting of resource use before using the information for incentives or public reporting (*See* section II.G.3. of this proposed rule). A few commenters suggested avoidable readmission rates as a good measure of both cost and quality of care. Commenters emphasized the importance of CMS working with health professionals on the selection of quality and cost measures.

Commenters generally agreed with the Issues Paper assumption that the Plan should address multiple levels of accountability, including individual health professionals, care teams, group practices, and accountable care entities. A few commenters mentioned that performance measurement at the regional level could help address regional variation. Consumer advocates made strong arguments for individual accountability, while noting that care delivery is ultimately a team effort. Others noted that measurement is more difficult at the individual level and that accountability at more aggregated levels could support promising payment models like bundled payment, gainsharing, and shared savings.

(3) Incentives

Commenters noted that incentive payments should be large enough to be meaningful, be made timely, and at least cover the cost of participating in the program. Commenters encouraged us to coordinate the incentives, as well as measures, with other payers. Many commenters stated that incentives should reward both improvement and attainment, and not be based on a ranking system that rewards only high attainers; instead, all who perform above a certain prospective benchmark should earn the incentive. Several commenters indicated that use of incentives could be an effective way to promote the use of effective HIT. Most commenters agreed that more than one incentive structure would be necessary to address different practice arrangements and to focus effort on specific objectives (for example, care coordination).

(4) Data Strategy and Infrastructure

Commenters emphasized that the administrative burden of data exchange, for both health professionals and CMS, should be minimized. Several commenters noted that clinical data registries and direct reporting from electronic health records were superior approaches to claims-based reporting for gathering clinical data. Commenters indicated that feedback on performance should be timely and detailed enough to be actionable. Commenters also asked for the opportunity to review and appeal the accuracy of their performance assessments prior to use of that information for payment incentives or public reporting.

(5) Public Reporting

Consumer advocates highlighted the importance of transparency while professional associations urged caution to assure that publicly reported information not be inaccurate or misleading for consumers. Several commenters noted that public reporting should address multiple levels of accountability, including individual health professionals, the care delivery team, group practices, and at the regional level. All agreed that publicly reported information should be user-friendly.

d. Next Steps in Plan Development

Building on input from the Listening Session on the Issues Paper topics, the PVBP Workgroup has begun to develop potential recommendations for inclusion in the Report to Congress. The first step is to design various approaches for performance-based payment that will address the planning goal and objectives for different practice arrangements. This design process will include identifying appropriate measures and incentive structures, considering the necessary data infrastructure, and addressing public reporting options. Consideration will be given to approaches that:

(1) Overlay the current PFS, such as differential fee schedule payments based on measured performance or for providing a medical home;

(2) Address multiple levels of accountability, including individual health professionals, as well as larger teams or organizations; and

(3) Promote more integrated care through shared savings models and bundled payment arrangements.

We are seeking further public comment on the development of the PVBP plan and Report to Congress. Comments already submitted by participating in person at the December 9, 2008 Listening Session or as written comments following the Session, do not need to be resubmitted. At this time, we are soliciting original comments that were not previously submitted. Particularly, we are interested in the comments further discussing the issues of the appropriate level of accountability (for example, group practice, individual, region), and appropriate data submission mechanisms. The PVBP Workgroup will use public comment to inform its development of the Plan and Report to Congress.

5. Section 132: Incentives for Electronic Prescribing (E-Prescribing)—The E-Prescribing Incentive Program

a. Program Background and Statutory Authority

As defined in § 423.159(a), e-prescribing is the transmission using electronic media, of prescription or prescription-related information between a prescriber, dispenser, pharmacy benefit manager (PBM), or health plan, either directly or through an intermediary, including an e-prescribing network. E-prescribing includes, but is not limited to, two-way transmissions between the point of care and the dispenser.

As discussed in the CY 2009 PFS final rule with comment period (73 FR 69847), there are many potential advantages to e-prescribing. Yet, there has been limited adoption and use of electronic prescribing by physicians and other professionals who prescribe medications. It is estimated that only 12 percent of office-based prescribers currently use e-prescribing (Surescripts. ''National Progress Report on E-Prescribing.'' Welcome to the E-Prescribing Resource Center. 2008. Surescripts. 15 May 2009. *http://www.surescripts.com/downloads/NPR/national-progress-report.pdf*).

As described in the CY 2009 PFS final rule with comment period (73 FR 69847 through 69848), the MMA and the creation of the Medicare Prescription Drug Benefit Program (Part D) promoted the use of e-prescribing by requiring the adoption of uniform standards for the Medicare Part D electronic prescribing (''e-prescribing'') program. As required by section 1860D–4(e) of the Act, ''foundation standards'' were adopted on November 7, 2005 (70 FR 67568) and additional Part D e-prescribing standards were adopted on April 7, 2008, and were implemented April 1, 2009 (73 FR 18918). Section 1848(m) of the Act, as amended by section 132 of the MIPPA, further promotes the use of e-prescribing by authorizing incentive payments to eligible professionals or group practices who are ''successful electronic prescribers.'' This E-Prescribing Incentive Program is expected to encourage significant expansion of the use of e-prescribing by

authorizing a combination of financial incentives and payment adjustment and is separate from, and in addition to, any incentive payment that eligible professionals may earn through the PQRI program discussed in section II.G.2. of this proposed rule. Eligible professionals do not have to participate in PQRI to participate in the E-Prescribing Incentive Program (and vice versa).

For 2010, which is the second year of the E-Prescribing Incentive Program, the Secretary is authorized to provide successful e-prescribers, as defined in section 1848(m)(3)(B) of the Act and further discussed below in this section, an incentive payment equal to 2.0 percent of the total estimated (based on claims submitted not later than 2 months after the end of the reporting period) allowed charges for all covered professional services furnished during the 2010 reporting period. Covered professional services are defined under the statute to be services for which payment is made under, or is based on, the PFS and which are furnished by an eligible professional. The applicable electronic prescribing percent (2 percent) authorized for the 2010 E-Prescribing Incentive Program is the same as that authorized for the 2009 E-Prescribing Incentive Program.

Subject to section 1848(m)(2)(D) of the Act, as added by section 4101(f)(2)(B) of the HITECH Act (Title IV of Division B of the Recovery Act, together with Title XIII of Division A of the Recovery Act) (Pub. L. 111–5), which was enacted on February 17, 2009, the incentive payments for successful electronic prescribers for future years are authorized under section 1848(b)(2)(C) of the Act as follows:

- 1.0 percent for 2011.
- 1.0 percent for 2012.
- 0.5 percent for 2013.

Section 1848(m)(2)(D) of the Act, as added by section 4001(f)(2)(B) of the Recovery Act, specifies a limitation to the e-prescribing incentive in relation to whether the EHR incentive authorized by the Recovery Act is earned. Section 1848(m)(2)(D) of the Act specifically provides that the e-prescribing incentive does not apply to an eligible professional (or group practice), if, for the EHR reporting period, the eligible professional (or group practice) earns an incentive payment under the new Health Information Technology (HIT) incentive program authorized by the Recovery Act for eligible professionals who are meaningful EHR users. The new HIT incentive program for meaningful EHR users begins in 2011. Therefore, beginning in 2011, eligible professionals who earn an incentive under the new HIT incentive program for meaningful EHR users, with respect to a certified EHR technology that has e-prescribing capabilities, would not be eligible to earn a separate incentive payment for being a successful electronic prescriber under the E-prescribing Incentive Program.

In addition, under section 1848(a)(5)(A) of the Act, as added by section 132(b) of the MIPPA and amended by section 4001(f)(1) of the Recovery Act, a PFS payment adjustment applies beginning in 2012 to those who are not successful electronic prescribers. Specifically, for 2012, 2013, and 2014, if the eligible professional is not a successful electronic prescriber for the reporting period for the year, the fee schedule amount for covered professional services furnished by such professionals during the year shall be less than the fee schedule amount that would otherwise apply by:

- 1.0 percent for 2012.
- 1.5 percent for 2013.
- 2.0 percent for 2014.

We note that the criteria for determination of successful electronic prescriber proposed herein may not necessarily be the criteria that will be used to determine the applicability of the payment adjustment in the future. Policy considerations underlying the application of the incentive payment are not necessarily the same as those in applying a payment adjustment. In general, we believe that an incentive should be broadly available to encourage the widest possible adoption of e-prescribing, even for low volume prescribers. On the other hand, a payment adjustment should be applied primarily to assure that those who have a large volume of prescribing do so electronically, without penalizing those for whom the adoption and use of an e-prescribing system may be impractical given the low volume of prescribing. We will discuss the application of the payment adjustment in future notice and comment rulemaking, but prior to the beginning of the reporting period that will be used to determine the applicability of the payment adjustment.

Under section 1848(m)(6)(A) of the Act, the definition of ''eligible professional'' for purposes of eligibility for the E-Prescribing Incentive Program is identical to the definition of ''eligible professional'' for the PQRI under section 1848(k)(3)(B) of the Act. In other words, eligible professionals include physicians, other practitioners as described in section 1842(b)(18)(C) of the Act, physical and occupational therapists, qualified speech-language pathologists, and qualified audiologists. However, for purposes of the E-prescribing Incentive Program, eligibility is further restricted by scope of practice to those professionals who have prescribing authority. Detailed information about the types of professionals that are eligible to participate in the E-Prescribing Incentive Program is available on the ''Eligible Professionals'' page of the E-Prescribing Incentive Program section of the CMS Web site at *http://www.cms.hhs.gov/ERXIncentive*.

Similar to the PQRI, the E-Prescribing Incentive Program, in 2009, is an incentive program in which determination of whether an eligible professional is a successful electronic prescriber will be made at the individual professional level, based on the NPI. Inasmuch as some individuals (identified by NPIs) may be associated with more than one practice or TIN, the determination of whether an eligible professional is a successful electronic prescriber will be made to the holder of each unique TIN/NPI combination. Then, payment will be made to the applicable holder of the TIN. For 2010, the determination of whether an eligible professional is a successful electronic prescriber will continue to be made for each unique TIN/NPI combination. However, section 1848(m)(3)(C) of the Act requires the Secretary by January 1, 2010 to establish and have in place a process under which eligible professionals in a group practice (as defined by the Secretary) shall be treated as meeting the requirements for submitting data on electronic prescribing quality measures for covered professional services for a reporting period (or, for purposes of the payment adjustment under section 1848(a)(5) of the Act, for a reporting period for a year) if, in lieu of reporting the electronic prescribing measure, the group practice reports measures determined appropriate by the Secretary, such as measures that target high-cost chronic conditions and preventive care, in a form and manner, and at a time specified by the Secretary. Therefore, in addition to making incentive payments for 2010 to group practices based on separately analyzing whether the individual eligible professionals within the group practice are successful electronic prescribers, we will also begin making incentive payments to group practices based on the determination that the group practice, as a whole, is a successful electronic prescriber.

b. The Proposed 2010 Reporting Period for the E-Prescribing Incentive Program

Section 1848(m)(6)(C)(i)(II) of the Act defines ''reporting period'' for the 2010

E-Prescribing Incentive Program to be the entire year. Section 1848(m)(6)(C)(ii) of the Act, as added by the MIPPA, however, authorizes the Secretary to revise the reporting period for years after 2009 if the Secretary determines such revision is appropriate, produces valid results on measures reported, and is consistent with the goals of maximizing scientific validity and reducing administrative burden. We propose the 2010 E-Prescribing Incentive Program reporting period will be the entire year (January 1, 2010–December 31, 2010). We believe that keeping the 2010 E-Prescribing Incentive Program reporting period consistent with the 2009 E-Prescribing Incentive Program reporting period will help to maintain program stability and be less confusing for eligible professionals.

Successful electronic prescribers would be eligible to receive an incentive payment equal to 2.0 percent of the total estimated allowed charges (based on claims submitted by no later than February 28, 2011) for all covered professional services furnished January 1, 2010 through December 31, 2010.

c. Proposed Criteria for Determination of Successful E-Prescriber for Eligible Professionals

Under section 1848(m)(3)(B) of the Act, in order to qualify for the incentive payment, an eligible professional must be a ''successful electronic prescriber,'' which the Secretary is authorized to identify using 1 of 2 possible criteria. One criterion, under section 1848(m)(3)(B)(ii) of the Act, is based on the eligible professional's reporting, in at least 50 percent of the reportable cases, on any e-prescribing quality measures that have been established under the physician reporting system under subsection 1848(k) (which, as noted previously, we have named ''PQRI'' for ease of reference) and are applicable to services furnished by the eligible professional during a reporting period. The second criterion, under section 1848(m)(3)(B)(iii) of the Act, is based on the electronic submission by the eligible professional of a sufficient number (as determined by the Secretary) of prescriptions under Part D during the reporting period. If the Secretary decides to use the latter standard, then, in accordance with section 1848(m)(3)(B)(iv) of the Act, the Secretary is authorized to use Part D drug claims data to assess whether a ''sufficient'' number of prescriptions has been submitted by eligible professionals. However, under section 1848(m)(3)(B)(i) of the Act, if the standard based on a sufficient number (as determined by the Secretary) of electronic Part D prescriptions is applied for a particular reporting period, then the standard based on the reporting on e-prescribing measures would no longer apply.

For 2009, as described in the CY 2009 PFS final rule with comment period (73 FR 69847 through 69852), we required eligible professionals to report on the e-prescribing measure that had been previously used in the 2008 PQRI. For 2010, we propose to continue to require eligible professionals to report on the electronic prescribing measure used in the 2009 E-Prescribing Incentive Program to determine whether an eligible professional is a successful e-prescriber, but we propose to use modified reporting criteria.

As we stated in the CY 2009 PFS final rule with comment period (73 FR 69848), we intend to consider the use of a certain number of Part D prescribing events as the basis for the incentive payment in future years. However, we do not believe that it is feasible to move to this substitute requirement in 2010. The accuracy and completeness of the Part D data with respect to whether a prescription was submitted electronically is unknown. Information on whether a prescription was submitted electronically by an individual eligible professional will not be collected on the Part D claims, or prescription drug event (PDE) data, until 2010. Also, prescription drug plan sponsors were not required to send PDE data with an individual prescriber's NPI until April 1, 2009. We currently have no information on the accuracy and completeness of the NPI data that is submitted with the PDE data. The NPI is needed in order for us to be able to link an eligible professional's PDE data to his or her Medicare Part B claims to calculate the incentive payment amount. During 2010, we expect to evaluate the adequacy of Part D data to determine the feasibility of its use for determining whether an eligible professional qualifies as a successful e-prescriber in future years.

(1) Reporting the Electronic Prescribing Measure

For 2009, we limited the reporting mechanism for the electronic prescribing measure to claims-based reporting. For 2010, we propose 3 reporting mechanisms for individual eligible professionals. First, we propose to retain the claims-based reporting mechanism that is used in the 2009 E-Prescribing Incentive Program. In addition, similar to the PQRI, for the E-prescribing Incentive Program, we propose to implement a registry-based reporting mechanism and, depending on whether we finalize the proposed EHR-based reporting mechanism for PQRI, we are also proposing that an EHR-based reporting mechanism be available for the electronic prescribing measure. In other words, eligible professionals would be able to choose whether to submit data on the electronic prescribing measure through claims, a qualified registry, or a qualified EHR product. As we stated in our discussion of the proposed PQRI reporting mechanisms for 2010 in section II.G.2.d. of this proposed rule, we recognize that one mode of quality reporting does not suit all practices. Similar to the PQRI, we believe that having multiple reporting mechanisms for the reporting of the electronic prescribing measure should increase opportunities for eligible professionals to successfully report the electronic prescribing measure. We invite comments on our proposal to provide alternatives to the claims-based reporting mechanism for reporting the electronic prescribing measure.

We propose that only registries qualified to submit quality measure results and numerator and denominator data on quality measures on behalf of eligible professionals for the 2010 PQRI would be qualified to submit measure results and numerator and denominator data on the electronic prescribing measure on behalf of eligible professionals for the 2010 E-Prescribing Incentive Program. We note that not all registries qualified to submit quality measure results and numerator and denominator data on quality measures on behalf of eligible professionals for the 2010 PQRI would be qualified to submit quality measure results and numerator and denominator data on the e-prescribing measure. PQRI qualified registries will be qualified to submit specific types of measures. The electronic prescribing measure is reportable by an eligible professional any time he or she bills for one of the procedure codes for Part B services included in the measure's denominator. Some registries who self-nominate to become a qualified registry for PQRI may not choose to self-nominate to become a qualified registry for submitting measures that require reporting at each eligible visit. Registries will need to indicate their desire to qualify to submit measure results and numerator and denominator data on the electronic prescribing measure for the 2010 E-Prescribing Incentive Program at the time that they submit their self-nomination letter for the 2010 PQRI. The self-nomination process and

requirements for registries for the PQRI, which also would apply to the registries for the 2010 E-Prescribing Incentive Program, are discussed in section II.G.2.d.(4) of this proposed rule. We will post a list of qualified registries for the 2010 E-Prescribing Incentive Program on the E-Prescribing Incentive Program section of the CMS Web site at *http://www.cms.hhs.gov/ERXIncentive* when we post the list of qualified registries for the 2010 PQRI on the PQRI section of the CMS Web site.

Similarly, we propose that only EHR products ''qualified'' to potentially be able to submit clinical quality data extracted from the EHR to CMS for the 2010 PQRI would be considered ''qualified'' for the purpose of an eligible professional potentially being able to submit data on the electronic prescribing measure for the 2010 E-Prescribing Incentive Program. The self-nomination process and requirements for EHR vendors for the PQRI, which also would apply to the EHR vendors for the 2010 E-Prescribing Incentive Program are discussed in section II.G.2.d.(5) of this proposed rule. EHR vendors will need to indicate their desire to have one or more of their EHR products qualified for the purpose of an eligible professional potentially being able to submit data on the electronic prescribing measure for the 2010 E-Prescribing Incentive Program at the time that they submit their self-nomination letter for the 2010 PQRI. If we finalize the EHR-based reporting mechanism for the 2010 PQRI, we will post a list of qualified EHR vendors and their products (including the version that is qualified) for the 2010 E-Prescribing Incentive Program, on the E-Prescribing Incentive Program section of the CMS Web site at *http://www.cms.hhs.gov/ERXIncentive* when we post the list of qualified EHR products for the 2010 PQRI on the PQRI section of the CMS Web site. We welcome comments on our proposal to limit the registries and EHR products qualified to submit the electronic prescribing measure for the 2010 E-Prescribing Incentive Program to those that are qualified registries and EHR products, respectively, for the 2010 PQRI.

(2) The Reporting Denominator for the Electronic Prescribing Measure

The electronic prescribing measure, similar to the PQRI measures, has 2 basic elements. These include: (1) A reporting denominator that defines the circumstances when the measure is reportable; and (2) a reporting numerator.

The denominator for the electronic prescribing measure consists of specific billing codes for professional services. The measure becomes reportable when any one of these procedure codes is billed by an eligible professional as Part B covered professional services. For 2009, the codes included in the measure's denominator were codes that are typically billed for services in the office or outpatient setting furnished by physicians or other eligible professionals. There are no diagnosis codes or age/gender requirements in order to be included in the measure's denominator (that is, reporting of the e–prescribing measure is not further limited to certain ages or a specific gender). However, as discussed further under section II.G.5.c.(5) of this proposed rule, eligible professionals are not required to report this measure in all cases in which the measure is reportable. Physicians and other eligible professionals who do not bill for one of the procedure codes for Part B covered professional services included in the measure's denominator will have no occasion to report the electronic prescribing measure.

Currently, the denominator codes for the electronic prescribing measure consist of the following CPT and G-codes: 90801; 90802; 90804; 90805; 90806; 90807; 90808; 90809; 92002; 92004; 92012; 92014; 96150; 96151; 96152; 99201; 99202; 99203; 99204; 99205; 99211; 99212; 99213; 99214; 99215; 99241; 99242; 99243; 99244; 99245; G0101; G0108; G0109.

As initially required under section 1848(k)(2)(A)(ii) of the Act, and further established through rulemaking and under section 1848(m)(2)(B) of the Act, however, we may modify the codes making up the denominator of the electronic prescribing measure. As such, we propose, in response to public comments received, to expand the scope of the denominator codes for 2010 to professional services outside the professional office and outpatient setting, such as professional services furnished in skilled nursing facilities or the home care setting. We propose to add the following CPT codes to the denominator of the electronic prescribing measure for 2010: 99304; 99305; 99306; 99307; 99308; 99309; 99310; 99315; 99316; 99341; 99342; 99343; 99344; 99345; 99347; 99348; 99349; 99350; and 90862. The proposed expansion of the electronic prescribing measure denominator is expected to provide more eligible professionals the opportunity to report the measure, and thus, provide more opportunities for eligible professionals to participate in the E-Prescribing Incentive Program. We invite comments on the proposed changes to codes identified for the electronic prescribing measure denominator.

By December 31, 2009, we will post the final specifications of the measure on the ''E-Prescribing Measure'' page of the E-Prescribing Incentive Program section of the CMS Web site at *http://www.cms.hhs.gov/ERXIncentive*.

(3) Qualified Electronic Prescribing System—Required Functionalities and Part D E-Prescribing Standards

To report the electronic prescribing measure in 2010, we propose that the eligible professional must report 1 of 3 ''G'' codes, as will be discussed below. However, in reporting any of the G-codes and thereby qualifying for the incentive payment for e-prescribing in 2010, the professional must have and regularly use a ''qualified'' electronic prescribing system as defined in the electronic prescribing measure specifications. If the professional does not have general access to an e-prescribing system in the practice setting, there is nothing to report. *Required Functionalities* for a *''Qualified'' Electronic Prescriber System*. What constitutes a ''qualified'' electronic prescribing system is based upon certain required functionalities that the system can perform. As currently specified in the measure, a ''qualified'' electronic prescribing system is one that can:

(a) Generate a complete active medication list incorporating electronic data received from applicable pharmacies and PBMs, if available.

(b) Allow eligible professionals to select medications, print prescriptions, electronically transmit prescriptions, and conduct alerts (written or acoustic signals to warn the prescriber of possible undesirable or unsafe situations including potentially inappropriate dose or route of administration of a drug, drug-drug interactions, allergy concerns, or warnings and cautions). This functionality must be enabled.

(c) Provide information related to lower cost, therapeutically appropriate alternatives (if any). The ability of an electronic prescribing system to receive tiered formulary information, if available, would suffice for this requirement for 2010 and until this function is more widely available in the marketplace.

(d) Provide information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan (if available).

Part D E-Prescribing Standards. Section 1848(m)(3)(B)(v) of the Act, to the extent practicable, in determining whether an eligible professional is a successful e-prescriber, ''the Secretary shall ensure that eligible professionals utilize electronic prescribing systems in compliance with standards established for such systems pursuant to the Part D Electronic Prescribing Program under section 1860D–4(e)'' of the Act. The Part D standards for electronic prescribing systems establish which electronic standards Part D sponsors, providers, and dispensers must use when they electronically transmit prescriptions and certain prescription related information for Part D covered drugs that are prescribed for Part D eligible individuals. To be a qualified electronic prescribing system under the E-prescribing Incentive Program, electronic systems must convey the information listed above under (a) through (d) using the standards currently in effect for the Part D e-prescribing program. Additional Part D e-prescribing standards were implemented April 1, 2009. These latest Part D e-prescribing standards, and those that had previously been adopted, can be found on the CMS Web site at *http://www.cms.hhs.gov/eprescribing.*

To ensure that eligible professionals utilize electronic prescribing systems that meet these requirements, the electronic prescribing measure requires that those functionalities required for a ''qualified'' electronic prescribing system must utilize the adopted Part D e-prescribing standards. The Part D e-prescribing standards relevant to the four functionalities for a ''qualified'' system in the electronic prescribing measure, described above and listed as (a), (b), (c), and (d), are:

(a) *Generate medication list*—Use the National Council for Prescription Drug Programs (NCPDP) Prescriber/Pharmacist Interface SCRIPT Standard, Implementation Guide, Version 8, Release 1, October 2005 (hereinafter ''NCPDP SCRIPT 8.1'') Medication History Standard;

(b) *Transmit prescriptions electronically*—Use the NCPDP SCRIPT 8.1 for the transactions listed at § 423.160(b)(2);

(c) *Provide information on lower cost alternatives*—Use the NCPDP Formulary and Benefits Standard, Implementation Guide, Version 1, Release 0 (Version 1.0), October 2005 (hereinafter ''NCPDP Formulary and Benefits 1.0'');

(d) *Provide information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan*—use:

(1) NCPDP Formulary and Benefits 1.0 for communicating formulary and benefits information between prescribers and plans.

(2) Accredited Standards Committee (ASC) X12N 270/271—Health Care Eligibility Benefit Inquiry and Response, Version 4010, May 2000, Washington Publishing Company, 004010X092 and Addenda to Health Care Eligibility Benefit Inquiry and Response, Version 4010A1, October 2002, Washington Publishing Company, 004010X092A1 for communicating eligibly information between the plan and prescribers.

(3) NCPDP Telecommunication Standard Specification, Version 5, Release 1 (Version 5.1), September 1999, and equivalent NCPDP Batch Standard Batch Implementation Guide, Version 1, Release 1 (Version 1.1), January 2000 for communicating eligibility information between the plan and dispensers.

There are, however, Part D e-prescribing standards that are in effect for functionalities that are not commonly utilized at this time. Such functionalities are not currently required for a ''qualified'' system under the electronic prescribing measure. One example is Rx Fill Notification, which is discussed in the Part D e-prescribing final rule (73 FR 18918, 18926). For purposes of the 2010 Electronic Prescribing Program and incentive payments, it is not required that the electronic prescribing system contain all functionalities for which there are available Part D e-prescribing standards. Rather, the only required functionalities are those stated in the measure and described above in the section entitled ''Required Functionalities for a 'Qualified' Electronic Prescribing System.'' For those required functionalities described above, we propose that a ''qualified'' system must use the adopted Part D e-prescribing standards for electronic messaging.

There are other aspects of the functionalities for a ''qualified'' system that are not dependent on electronic messaging and are part of the software of the electronic prescribing system, for which Part D standards for electronic prescribing do not pertain. For example, the requirements in qualification (b) listed above that require the system to allow professionals to select medications, print prescriptions, and conduct alerts are functions included in the particular software, for which Part D standards for electronic messaging do not apply.

We are aware that there are significant numbers of eligible professionals who are interested in earning the incentive payment, but currently do not have an electronic prescribing system. The electronic prescribing measure does not require the use of any particular system or transmission network; only that the system be a ''qualified'' system having the functionalities described above based on Part D e-prescribing standards.

(4) The Reporting Numerator for the Electronic Prescribing Measure

Currently, to report for an applicable case where 1 of the denominator codes is billed for Part B services, an eligible professional must report one of 3 G-codes specified in the electronic prescribing measure. Currently, the G-codes are the following:

- One G-code is used to report that all prescriptions in connection with the visit billed were electronically prescribed (G8443);
- Another G-code indicates that no prescriptions were generated during the visit (G8445); and
- A third G-code is used when some or all prescriptions were written or phoned in due to patient request, State or Federal law, the pharmacy's system being unable to receive the data electronically or because the prescription was for a narcotic or other controlled substance (G8446).

However, for 2010, we propose to modify the first G-code (G8443) to indicate that at least 1 prescription in connection with the visit billed was electronically prescribed. In addition, we propose to eliminate the 2 remaining G-codes from the measure's numerator: G8445; and G8446. We believe these modifications to the electronic prescribing measure will simplify reporting of the measure because the measure will only be reportable when an eligible professional has electronically prescribed. We invite comments on the proposed modifications to the electronic prescribing measure numerator.

The e-prescribing quality measure would not apply unless an eligible professional furnishes services indicated by one of the codes included in the measure's denominator. Therefore, for claims-based reporting, for example, it is not necessary for an eligible professional to report G-codes for the electronic prescribing measure on claims not containing one of the denominator codes. However, if reporting a G-code, the G-code data submission will only be considered valid if it appears on the same Part B claim containing one of the e-prescribing quality measure's denominator codes.

(5) Criteria for Successful Reporting of the Electronic Prescribing Measure

As discussed above, section 1848(m)(3)(B)(ii) of the Act specifies that an eligible professional shall be treated as a successful electronic prescriber for a reporting period based on the eligible professional's reporting of the electronic prescribing measure in at least 50 percent of applicable cases. However, section 1848(m)(3)(D) of the Act permits the Secretary in consultation with stakeholders and experts to revise the criteria for submitting data on electronic prescribing measures under section 1848(3)(B)(ii) of the Act for years after 2009. Therefore, we propose to revise the criteria for submitting data on the electronic prescribing measure. For 2010, rather than requiring that the electronic prescribing measure be reported for a certain proportion of reportable cases, we propose to make the determination of whether an eligible professional is a successful electronic prescriber based on a count of the number of times an eligible professional reports that at least one prescription created during the encounter was generated using a qualified e-prescribing system (that is, reports the modified G8443 code). We believe that modifying the criteria for submitting the electronic prescribing measure in this manner will bring us closer to our stated intention to transition to using a certain number of electronic Part D prescribing events as the basis for the incentive payment in future years. In proposing to revise the criteria for successful reporting of the electronic prescribing measure in this manner, we also assume that once an eligible professional has invested in an e-prescribing system, integrated the use of the e-prescribing system into the practice's work flows, and has used the system to some extent, he or she is likely to continue to use the e-prescribing system for most of the prescriptions he or she generates.

Preliminary data from the 2008 PQRI through September 2008 indicate that half of the eligible professionals who were eligible to report the electronic prescribing measure under the 2008 PQRI (measure #125) had 132 or more instances in which they were eligible to report the measure, with a maximum of 12,655 reporting instances. Therefore, in order to successfully report the measure under the 2009 criteria for successful e-prescribing (that is, reporting the measure for at least 50 percent of applicable cases), half of eligible professionals would have had to report measure #125 66 times or more (that is, 50 percent of 132 reporting instances), with a maximum of 6,328 times (that is, 50 percent of 12,655 reporting instances). For structural measures such as the electronic prescribing measure, once an eligible professional has demonstrated that he or she has integrated use of an e-prescribing system into his or her practice's work flow, requiring the eligible professional to continue to report the measure represents an administrative burden with little added benefit to the reliability and validity of the data being reported. In contrast, for clinical quality measures, the reliability and validity of the performance rates depends on the adequacy of the sample. Therefore, we propose that an eligible professional would be required to report that at least 1 prescription for a Medicare Part B FFS patient created during an encounter that is represented by 1 of the codes in the denominator of the electronic prescribing measure was generated using a qualified e-prescribing system for at least 25 times during the 2010 reporting period.

The proposed minimum reporting threshold of 25 is based on the notion that an eligible professional would need to e-prescribe, on average, for approximately 2 Medicare Part B FFS patient encounters per month during the reporting period in order to be considered a successful e-prescriber. The proposed reporting threshold of 25 also takes into consideration that prescriptions are not generated with every Medicare Part B FFS patient encounter and some prescriptions, such as narcotics, cannot be prescribed electronically.

We welcome comments on the proposed criteria for determination of successful electronic prescriber. We are particularly interested in comments related to the following:

- Our proposal to change the criteria for determining whether an eligible professional is a successful e-prescriber from requiring reporting of the electronic prescribing measure in 50 percent of applicable cases to a count of the number of times the eligible professional electronically prescribed; and
- The proposed threshold number of 25 times in which an eligible professional would be required to report that he or she electronically prescribed during the reporting period.

d. Determination of the 2010 Incentive Payment Amount for Individual Eligible Professionals Who Are Successful E-Prescribers

Section 1848(m)(2)(B) of the Act imposes a limitation on the E-prescribing incentive payment. The Secretary is authorized to choose 1 of 2 possible criteria for the limitation. The first criterion, under section 1848(m)(2)(B)(i) of the Act, is based upon whether the Medicare Part B allowed charges for covered professional services to which the electronic prescribing quality measure applies are less than 10 percent of the total Part B allowed charges for all covered professional services furnished by the eligible professional during the reporting period. The second criterion, under section 1848(m)(2)(B)(ii) of the Act, is based on whether the eligible professional submits (both electronically and nonelectronically) a sufficient number (as determined by the Secretary) of prescriptions under Part D (which can, again, be assessed using Part D drug claims data). If the Secretary decides to use the latter criterion, then, in accordance with section 1848(m)(2)(B) of the Act, the criterion based on the reporting on electronic prescribing measures would no longer apply. The statutory limitation also applies to the future application of the payment adjustment.

As discussed above, for 2010, we propose to make the determination of whether an eligible professional is a ''successful e-prescriber'' based on submission of the electronic prescribing measure. As a result, we propose to apply the criterion under section 1848(m)(2)(B)(i) for the limitation for the 2010 E-Prescribing Incentive Program. Therefore, in determining whether an eligible professional will receive an e-prescribing incentive payment for 2010, we would determine whether the 10 percent threshold is met based on the claims submitted by the eligible professional at the TIN/NPI level. This calculation is expected to take place in the first quarter of 2011 and would be performed by dividing the individual's total 2010 allowed charges for all such covered professional services submitted for the measure's HCPCS codes by the individual's total allowed charges for all covered professional services (as assessed at the TIN/NPI level). If the result is 10 percent or more, then the statutory limitation will not apply and a successful e-prescriber would earn the e-prescribing incentive payment. If the result is less than 10 percent, then the statutory limitation will apply and the eligible professional would not earn an e-prescribing incentive payment—even if he or she electronically prescribes and reports G8443 at least 25 times for those eligible cases that occur during the 2010 reporting period. Although an individual eligible professional may

decide to conduct his or her own assessment of how likely this statutory limitation is expected to apply to him or her before deciding whether or not to report the electronic prescribing measure, an individual eligible professional may report the electronic prescribing measure without regard to the statutory limitation for the incentive payment.

e. Proposed Reporting Option for Satisfactory Reporting of the E-Prescribing Measure by Group Practices

As discussed previously, section 1848(m)(3)(C)(i) requires that by January 1, 2010, the Secretary shall establish and have in place a process under which eligible professionals in a group practice (as defined by the Secretary) shall be treated as meeting the requirements for submitting data on electronic prescribing quality measures for covered professional services for a reporting period (or, for purposes of the payment adjustment under subsection (a)(5), for a reporting period for a year) if, in lieu of reporting the electronic prescribing measure, the group practice reports measures determined appropriate by the Secretary, such as measures that target high-cost chronic conditions and preventive care, in a form and manner, and at a time specified by the Secretary.

Section 1848(m)(3)(C)(ii) of the Act requires that the process established under section 1848(m)(3)(C)(i) of the Act provide for the use of a statistical sampling model to submit data on measures, such as the model used under the Physician Group Practice demonstration project under section 1866A of the Act. In addition, section 1848(m)(3)(C)(iii) of the Act specifies that payments to a group practice by reason of the process established under section 1848(m)(3)(C)(ii) of the Act shall be in lieu of the payments that would otherwise be made under this subsection to eligible professionals in the group practice for being a successful e-prescriber. Therefore, while we will be making incentive payments to group practices based on the determination that the group practice, as a whole, is a successful e-prescriber for 2010, an individual eligible professional who is affiliated with a group practice participating in the group practice reporting option that successfully meets the proposed requirements for group practices would not be eligible to earn a separate e-prescribing incentive payment for 2010 on the basis of his or her successfully reporting the electronic prescribing measure at the individual level.

(1) Definition of ''Group Practice''

As stated above, section 1848(m)(3)(C)(i) of the Act authorizes the Secretary to define ''group practice.'' For purposes of determining whether a group practice is a successful e-prescriber, we propose that a ''group practice'' would consist of a physician group practice, as defined by a TIN, with at least 200 or more individual eligible professionals (or, NPIs) who have reassigned their billing rights to the TIN to be consistent with definition of ''group practice'' proposed for the PQRI group practice reporting option.

However, we propose to limit the group practices eligible to participate in the 2010 E-Prescribing Incentive Program through the group practice reporting option to those group practices selected to participate in the PQRI group practice reporting option. At this time, we would like to limit the number of groups participating in the group practice reporting option until we get further experience with the group practice reporting option. Therefore, unlike individual eligible professionals who are not required to participate in the PQRI to be eligible to earn an e-prescribing incentive and vice versa, group practices would be required to participate in both PQRI and the E-Prescribing Incentive Program. As discussed in section II.G.2.g. of this proposed rule, group practices interested in participating in the 2010 PQRI through the group practice reporting option would be required to submit a self-nomination letter to CMS or a CMS designee requesting to participate in the 2010 PQRI group practice reporting option. Instructions for submitting the self-nomination letter will be posted on the PQRI section of the CMS Web site by November 15, 2009. In addition to meeting the eligibility requirements proposed in section II.G.2.g.(1) of this proposed rule, a group practice would also have to indicate how they intend to report the electronic prescribing measure (that is, which proposed reporting mechanism the group practice intends to use) for purposes of participating in the 2010 E-Prescribing Incentive Program group practice reporting option.

(2) Process for Group Practices to Participate as Group Practices and Criteria for Successful Reporting of the E-Prescribing Measure by Group Practices

For group practices selected to participate in the e-prescribing group practice reporting option for 2010, we propose the reporting period would be January 1, 2010 to December 31, 2010.

We propose that physician groups selected to participate in the 2010 E-Prescribing Incentive Program through the group practice reporting option would be able to choose to report the electronic prescribing measure through the claims-based, the registry-based, or, contingent upon us finalizing this reporting mechanism for the 2010 PQRI, the EHR-based reporting mechanism. As we proposed for individual eligible professionals, only registries and EHR products qualified to participate in the 2010 PQRI would be qualified for purposes of the 2010 e-prescribing group practice reporting option.

In order for a group practice to be considered a successful e-prescriber, we propose the group practice would have to report that at least 1 prescription during an encounter was generated using a qualified e-prescribing system in at least 2,500 instances during the reporting period.

In the absence of information about the composition of the group practices that may wish to participate in the E-Prescribing Incentive Program through the group practice reporting option rather than as individual eligible professionals, we assumed that the average group practice consists of 200 eligible professionals and that as many as half of the members of an average group practice do not furnish the services represented by the electronic prescribing measure's denominator codes, and thus, would not have an opportunity to report the electronic prescribing measure. Second, to be consistent with the proposed reporting criteria for individual eligible professionals, we also believe that each eligible professional in a group practice should be required to report that at least 1 prescription generated during an encounter that is represented by 1 of the electronic prescribing measure's denominator codes was generated electronically at least 25 times. Thus, for a group of 200 eligible professionals, we could extrapolate from our assumption that only half of the eligible professionals in an average practice of 200 eligible professionals would have the opportunity to report the electronic prescribing measure per group practice, the total number of reporting instances for the 100 remaining eligible professionals would be 2,500. We invite comments on the proposed criteria for determining whether a group practice is a successful e-prescriber. We also invite feedback on our underlying assumptions.

Section 1848(m)(2)(B) of the Act specifies that the limitation on the applicability of the e-prescribing incentive discussed in section II.G.5.d.

of this proposed rule applies to group practices as well as individual eligible professionals. Therefore, in determining whether a group practice will receive an e-prescribing incentive payment for 2010 by meeting the proposed reporting criteria described above, we would determine whether the 10 percent threshold is met based on the claims submitted by the group practice. This calculation is expected to take place in the first quarter of 2011 and would be determined by dividing the group practice's total 2010 allowed charges for all covered professional services submitted for the measure's HCPCS codes by the group practice's total Medicare Part B allowed charges for all covered professional services. If the result is 10 percent or more, then the statutory limitation will not apply and a group practice that is determined to be a successful e-prescriber would qualify to earn the e-prescribing incentive payment. If the result is less than 10 percent, then the statutory limitation will apply and the group practice would not qualify to earn the e-prescribing incentive payment.

f. Public Reporting of Names of Successful E-Prescribers

As discussed in section II.G.2.k. of this proposed rule, section 1848(m)(5)(G) of the Act requires the Secretary to post on the CMS Web site, in an easily understandable format, a list of the names of eligible professionals (or group practices) who satisfactorily submit data on quality measures for the PQRI and the names of the eligible professionals (or group practices) who are successful e-prescribers. In accordance with section 1848(m)(5)(G) of the Act, we indicated in the CY 2009 PFS final rule with comment period (73 FR 69851 through 69852) our intent, in 2010, to post the names of eligible professionals who are successful e-prescribers for the 2009 E-Prescribing Incentive Program at *http://www.medicare.gov*.

As required by section 1848(m)(5)(G) of the Act, we propose to make public the names of eligible professionals and group practices who are successful electronic prescribers for the 2010 E-Prescribing Incentive Program on the Physician and Other Health Care Professionals Directory. The names of individual eligible professionals and group practices who are successful electronic prescribers for the 2010 E-Prescribing Incentive Program will be available in 2011 after the 2010 incentive payments are paid.

For purposes of publicly reporting the names of individual eligible professionals on the Physician and Other Health Care Professionals Directory, we propose to post the names of individual eligible professionals: (1) Whose 2010 PFS allowed charges make up at least 10 percent of the eligible professional's Medicare Part B charges for 2010; (2) who report that at least 1 prescription generated during an encounter included in the electronic prescribing measure denominator was generated electronically (that is, who reported the G8443 code) at least 25 times during the 2010 reporting period; and (3) who receive an e-prescribing incentive payment for covered professional services furnished January 1, 2010 through December 31, 2010. Since the PQRI and the E-Prescribing Incentive Program are two separate incentive programs and individual eligible professionals are not required to participate in both programs to earn an incentive under either program, it is possible for an eligible professional who participates in both incentive programs to be listed both as an individual eligible professional who satisfactorily submits data on quality measures for the PQRI and a successful electronic prescriber if he or she meets the criteria for both incentive programs.

For purposes of publicly reporting the names of group practices on the Physician and Other Health Care Professionals Directory, we propose to post the names of group practices who: (1) Report that at least 1 prescription generated during an encounter included in the electronic prescribing measure denominator was generated electronically (that is, who reported the G8443 code) at least 2500 times during the 2010 reporting period; and (2) receive an e-prescribing incentive payment for covered professional services furnished January 1, 2010 through December 31, 2010. Although group practices would be required to participate in both programs to earn an incentive under either program, the criteria for satisfactory reporting of PQRI measures for group practices are different from the criteria for successful reporting of the electronic prescribing measure by group practices. Therefore, it is possible for a group practice to be listed as a group practice that satisfactorily submits data on quality measures for the PQRI but not as a successful electronic prescriber or vice versa.

6. Section 135: Implementation of Accreditation Standards for Suppliers Furnishing the Technical Component (TC) of Advanced Diagnostic Imaging Services

Section 1834(e) of the Act, as added by section 135(a) of the MIPPA, requires that beginning January 1, 2012, Medicare payment may only be made for the technical component (TC) of advanced diagnostic imaging services for which payment is made under the fee schedule established in section 1848(b) of the Act to a supplier who is accredited by an accreditation organization designated by the Secretary.

a. Accreditation Requirement

This proposed rule would set forth the criteria for designating organizations to accredit suppliers furnishing the technical component (TC) of advanced diagnostic imaging services as specified in section 1834(c) of the Act. In addition, it would set forth the required procedures to ensure that the criteria used by an accreditation organization meet minimum standards for each imaging modality. These statutory requirements would be codified in § 414.68 of the payment rules for physicians and other practitioners.

The CMS-designated accreditation organization would apply standards that set qualifications for medical personnel who are not physicians but who furnish the TC. The standards would describe the qualifications and responsibilities of medical directors and supervising physicians including the following: Recognizing whether a particular medical director or supervising physician received training in advanced imaging services in a residency program; and has attained, through experience, the necessary expertise to be a medical director or supervising physician; has completed any continuing medical education courses related to advanced imaging services; or has met such other standards as the Secretary determines appropriate. In addition, the standards would require suppliers to: (1) Establish and maintain a quality control program to ensure the technical quality of diagnostic images produced by the supplier; (2) ensure the equipment used meets performance specifications; and (3) ensure safety of personnel. While the statute authorizes the Secretary to establish as criteria for accreditation any other standards or procedures the Secretary determines appropriate, we are not proposing to establish other standards or procedures at this time.

We expect to publish a notice to solicit applications from entities for the purposes of becoming a designated accreditation organization the same day that this proposed rule's subsequent final rule is issued, on or before November 1, 2009. Due to the tight timeframe, we expect to meet the January 1, 2010 statutory deadline in

order to designate organizations to accredit suppliers furnishing the TC of advanced diagnostic imaging services by waiving the 60-day delay in the imaging accreditation provisions of the final rule.

b. Accreditation for Suppliers

Section 1834(e) of the Act requires the Secretary to designate and approve accreditation organizations to accredit suppliers of the TC of advanced diagnostic imaging services. To promote consistency in accrediting providers and suppliers throughout the Medicare program, we are proposing to use existing procedures for the application, selection, and oversight of accreditation organizations detailed at 42 CFR part 488, subparts A and D and apply them to organizations accrediting suppliers of the TC of advanced diagnostic imaging services. We are proposing modifications to the existing part 488 requirements to meet the specialized needs of the advanced imaging industry. These modifications will require an independent accreditation organization applying for approval as a designated accreditation organization to include in their application:

• A detailed description of how the organization's accreditation criteria satisfy the statutory standards at section 1834(e)(3) of the Act, specifically:

+ Qualifications of medical personnel who are not physicians and who furnish the TC of advanced diagnostic imaging services;

+ Qualifications and responsibilities of medical directors and supervising physicians, such as training in advanced diagnostic imaging services in a residency program, expertise obtained through experience, or continuing medical education courses;

+ Procedures to ensure the safety of persons who furnish the TC of advanced diagnostic imaging services and individuals to whom such services are furnished;

+ Procedures to ensure the reliability, clarity, and accuracy of the technical quality of diagnostic images produced by the supplier.

• An agreement to conform accreditation requirements to any changes in Medicare statutory requirements in section 1834(e) of the Act.

• Information to demonstrate the accreditation organization's knowledge and experience in the advanced diagnostic imaging arena.

• The organization's proposed fees for accreditation for each modality in which the organization intends to offer accreditation and any plans for reducing the burden and cost of accreditation to small and rural suppliers.

• Any specific documentation requirements and attestations requested by CMS as a condition of designation under this part.

If, after review of an accreditation organization's submission of information, we determine that additional information is necessary to make a determination for approval or denial of the accreditation organization's application to be designated as an accreditation organization for suppliers of the TC of advanced diagnostic imaging services, the organization will be notified and afforded an opportunity to provide the additional information. We may visit the organization's offices to verify representations made by the organization in its application, including, but not limited to, review of documents and interviews with the organization's staff. The accreditation organization will receive a formal notice from CMS stating whether the request for designation has been approved or denied. If approval was denied, the notice will include the basis for denial and outline the reconsideration procedures. We will make every effort to issue a final decision no more than 30 calendar days from the time the completed reapplication is received by CMS. An accreditation organization may withdraw its application for designation under section 1834(e) of the Act at any time before the formal notice of approval is received. An accreditation organization that has been notified that its request for designation has been denied may request reconsideration in accordance with § 488.201 through § 488.211 in Subpart D. Any accreditation organization whose request for designation has been denied may resubmit its application if the organization (1) revises its accreditation program to address the rationale for denial of its previous request; (2) provides reasonable assurance that its accredited companies meet applicable Medicare requirements; and (3) resubmits the application in its entirety. If an accreditation organization has requested a reconsideration of our determination that its request for designation under section 1834(e) of the Act is denied, it may not submit a new application for the type of modality that is at issue in the reconsideration until the reconsideration is final.

A panel will evaluate all proposals from accreditation organizations seeking designation under section 1834(e) of the Act using existing CMS survey and certification processes as established in § 488.4.

c. Payment Rules for Suppliers of the TC of Advanced Diagnostic Imaging Services (§ 414.68)

We would specify in § 414.68 the statutory requirement of section 1834(e) of the Act that all suppliers of the TC of advanced diagnostic imaging services be accredited by a CMS-designated accreditation organization by January 1, 2012 for payments made under the fee schedule established under section 1848(b). In § 414.68(a), we are proposing to define the following:

• ''Accredited supplier'' as a supplier that has been accredited by a CMS-approved accreditation organization.

• ''Advanced Diagnostic Imaging Services'' as diagnostic magnetic resonance imaging, computed tomography, nuclear medicine, and positron emission tomography. We are not proposing at this time to include other diagnostic imaging services in this definition under section 1834(e)(1)(B)(ii) of the Act.

• ''CMS-approved accreditation organization'' as an independent accreditation organization designated by CMS to perform the accreditation function established in section 1834(e) of the Act.

d. Ongoing Responsibilities of CMS-Approved Accreditation Organizations

We are proposing to require a CMS-approved accreditation organization to perform the following activities on an ongoing basis. Provide to CMS in written form and on an ongoing basis all of the following:

• Copies of all accreditation surveys of specific suppliers along with any survey-related information that we may require (including corrective action plans and summaries of CMS requirements that were not met).

• Notice of all accreditation decisions.

• Notice of all complaints related to suppliers of the TC of advanced diagnostic imaging service.

• Information about any suppliers of the TC of advanced diagnostic imaging service for which the accrediting organization has denied the supplier's accreditation status.

• Notice of any proposed changes in its accreditation standards or requirements or survey process. If the organization implemented the changes before or without CMS approval, we could withdraw approval of the accreditation organization.

• Permit its surveyors to serve as witnesses if CMS takes an adverse action based on accreditation findings.

• Provide CMS with written notice of any deficiencies and adverse actions

implemented by the CMS-approved accreditation organization against an accredited supplier of the TC of advanced diagnostic imaging within 2 days of identifying such deficiencies, if the deficiencies pose immediate jeopardy to a beneficiary or to the general public.

- Provide written notice of the withdrawal to all accredited suppliers within 10 days of CMS' notice to withdraw approval of the accreditation organization.
- Provide, on an annual basis, summary data specified by CMS that are related to the past year's accreditation activities and trends.

e. Continuing CMS Oversight of CMS-Approved Accreditation Organizations

We are proposing to add § 414.68 to establish specific criteria and procedures for continuing oversight and for withdrawing approval of an approved accreditation organization.

(1) Validation Audits

We are proposing to audit the accredited organizations in order to validate the survey accreditation process of approved accreditation organizations in the TC of advanced imaging. The audits would be conducted on a representative sample of suppliers who have been accredited by a particular accrediting organization or in response to allegations of supplier noncompliance with the standards. When conducted on a representative sample basis, we are proposing that the audit would be comprehensive and address all of the standards or would focus on a specific standard in issue. When conducted in response to an allegation, we will specify that the CMS team or our contractor would audit for any standard that we determined was related to the allegations. We are proposing to require a supplier selected for a validation audit to authorize the validation audit to occur and authorize the CMS team or our contractor to monitor the correction of any deficiencies found through the validation audit. If a supplier selected for a validation audit failed to comply with the requirements at § 414.68, the supplier would no longer meet the Medicare requirements and, under this proposal, the supplier's accreditation for the TC of the advanced medical imaging would be revoked.

We are proposing that a CMS team or our contractor would conduct an audit of an accredited organization, examine the results of the accreditation organization's own survey procedure onsite, or observe the accreditation organization's survey, in order to validate the organization's accreditation process. At the conclusion of the review, we would identify any accreditation programs for which validation audit results indicated the following:

- A 10 percent rate of disparity between findings by the accreditation organization and findings by CMS or our contractor on standards that did not constitute immediate jeopardy to patient health and safety if not met;
- Any disparity between findings by the accreditation organization and findings by CMS or our contractor on standards that constituted immediate jeopardy to patient health and safety if not met; or
- There were widespread or systemic problems in the organization's accreditation process such that the accreditation no longer provided assurance that suppliers met or exceeded the Medicare requirements, irrespective of the rate of disparity.

(2) Notice of Intent To Withdraw Approval for Designating Authority

If a validation audit, onsite observation, or our concerns with the ethical conduct (that impacts the health and safety of the beneficiary) of an accreditation organization suggest that the accreditation organization is not meeting the requirements of proposed § 414.68, we would provide the organization written notice of its intent to withdraw approval of the accreditation organization's designating authority.

(3) Withdrawal of Approval for Designating Authority

We are proposing to withdraw approval of an accreditation organization at any time if we determine that:

- Accreditation by the organization no longer provides sufficient assurance that the suppliers of the TC of advanced imaging meet the requirements of section 1834(e) of the Act and the failure to meet those requirements could pose an immediate jeopardy to the health and safety of Medicare beneficiaries;
- Constitutes a significant hazard to the public health; or
- The accreditation organization failed to meet its obligations for application and reapplication procedures.

(4) Reconsideration

We are proposing to implement requirements under part 488 without substantive changes as the requirements have been utilized for the health care providers covered under part 488 since 1992. We are proposing that an accreditation organization dissatisfied with a determination that its accreditation requirements did not provide or do not continue to provide reasonable assurance that the suppliers accredited by the accreditation organization met the applicable standards would be entitled to a reconsideration. We are also proposing to reconsider any determination to deny, remove, or not renew the approval of the designating authority to accreditation organizations if the accreditation organization filed a written request for reconsideration through its authorized officials or through its legal representative.

We are proposing to require the accreditation organization to file the request within 30 calendar days of the receipt of CMS notice of an adverse determination or non-renewal. We propose to require the request for reconsideration to specify the findings or issues with which the accreditation organization disagreed and the reasons for the disagreement. A requestor could withdraw its request for reconsideration at any time before the issuance of a reconsideration determination. In response to a request for reconsideration, we would provide the accrediting organization the opportunity for an informal hearing that would be conducted by a hearing officer appointed by the CMS Administrator and provide the accrediting organization the opportunity to present, in writing and in person, evidence or documentation to refute the determination to deny approval, or to withdraw or not renew its designating authority.

We would provide written notice of the time and place of the informal hearing at least 10 business days before the scheduled date. The informal reconsideration hearing would be open to CMS and the organization requesting the reconsideration, including authorized representatives, technical advisors (individuals with knowledge of the facts of the case or presenting interpretation of the facts), and legal counsel. The hearing would be conducted by the hearing officer who would receive testimony and documents related to the proposed action. Testimony and other evidence could be accepted by the hearing officer. However, it would be inadmissible under the usual rules of court procedures. The hearing officer would not have the authority to compel by subpoena the production of witnesses, papers, or other evidence. Within 45 calendar days of the close of the hearing, the hearing officer would

present the findings and recommendations to the accrediting organization that requested the reconsideration. The written report of the hearing officer would include separate numbered findings of fact and the legal conclusions of the hearing officer. The hearing officer's decision would be final.

We are interested in obtaining additional information on the role of radiology assistants (RA) and radiology practitioner assistants (RPA), including the level of physician supervision that would be appropriate when RAs and RPAs are involved in the performance of the TC of advanced medical imaging, whether the role varies by State, and related information. It would be particularly helpful for the commenter to identify specific clinical scenarios with associated CPT codes that would represent such services involving RAs and RPAs.

7. Section 139: Improvements for Medicare Anesthesia Teaching Programs

Section 139 of the MIPPA establishes a ''special payment rule for teaching anesthesiologists'' and provides a directive to the Secretary regarding payments for the services of ''teaching certified registered nurse anesthetists'' (teaching CRNAs). It also specifies the periods when the teaching anesthesiologist must be present during the procedure in order to receive payment for the case at 100 percent of the fee schedule amount (the regular fee schedule rate). These provisions are effective for services furnished on or after January 1, 2010.

a. Teaching Anesthesiologists: Special Payment Rule

The criteria for the payment of teaching anesthesiology services and the special rule for the teaching anesthesiologist are similar to the current criteria for payment of teaching surgeon services and the payment rule for the teaching surgeon involved in overlapping resident cases. Thus, there is a similarity in the payment rules for these physician specialties who work closely together.

(1) Payment for Anesthesia Services Furnished by a Physician

If the physician, usually an anesthesiologist, is involved in furnishing anesthesia services to a patient, the services can be furnished under one of three different scenarios. The anesthesiologist may—

- Personally perform the anesthesia services alone;
- Be involved in the case as a teaching anesthesiologist with an anesthesia resident; or
- Provide medical direction of the performance of anesthesia services for two, three or four concurrent cases involving a qualified individual (who may be a CRNA, an anesthesiologist assistant (AA), an anesthesia resident, or a student nurse anesthetist under certain circumstances).

Under the statute and CMS policy, if the anesthesiologist personally performs the anesthesia service alone or is involved in the case as a teaching anesthesiologist with an anesthesia resident, payment for the anesthesiologist's service is made at the regular fee schedule rate.

If the anesthesiologist furnishes medical direction for two, three or four concurrent anesthesia procedures, then payment for the anesthesiologist's service is made, in accordance with section 1848(a)(4)(B) of the Act, at 50 percent of the otherwise applicable fee schedule amount.

(2) Methodology for Payment of Anesthesia Services

Payment for anesthesia services furnished by a physician is made under the PFS, under section 1848(b)(2)(B) of the Act. The methodology for the calculation of the allowable amount is unique to anesthesia service only. Payment is made on the basis of anesthesia base units and time units, calculated from the actual anesthesia time of the case, instead of on the basis of work, PE, and malpractice RVUs. Payment for anesthesia services is also based on the anesthesia CF instead of the general PFS CF.

(3) Section 139(a) of the MIPPA

Section 139(a) of the MIPPA adds a new paragraph at section 1848(a)(6) of the Act to establish a ''special payment rule for teaching anesthesiologists''. This provision allows payment to be made at the regular fee schedule rate for the teaching anesthesiologist's involvement in the training of residents in either a single anesthesia case or in two concurrent anesthesia cases furnished on or after January 1, 2010. We will refer to anesthesia cases involving the training of residents as ''resident cases'' below in this section.

(4) Discussion

The Accreditation Council on Graduate Medical Education (ACGME) is a branch of the AMA, and it accredits allopathic residency programs. In order for a hospital to receive Medicare graduate medical education payments for its training programs, the residents must be in an ''approved medical residency program'' Under § 413.75(b), an approved medical residency program is one approved by one of the national organizations listed in § 415.152. One of the national organizations is the ACGME.

ACGME's policies and procedures require that each accredited residency program comply with the institutional requirements and the specialty program requirements. For approved anesthesia residency programs, ACGME requirements for faculty supervision and training of anesthesia residents specify that faculty members not direct anesthesia at more than two anesthetizing locations in the clinical setting. (*See* the ACGME Web site at *http://www.acgme.org*.)

Consistent with this requirement, the American Society of Anesthesiologists (ASA) has advised us that, when providing services in two concurrent cases, a teaching anesthesiologist might be engaged in two concurrent anesthesia resident cases, or in two mixed concurrent cases, one a resident case and the other a CRNA or AA case.

The statute applies the special payment rule for teaching anesthesiologists to the single resident case or two concurrent cases involving anesthesia residents as long as the teaching anesthesiologist meets the requirements in sections 1848(6)(A) and 1848(6)(B) of the Act. However, the statute does not directly address a single resident case that is concurrent to another case involving a CRNA, AA, or other qualified individual who can be medically directed. The issue is whether the medical direction payment rules apply to each of these cases or whether an alternative payment policy may apply.

One option in implementing this provision would be to strictly limit the special payment rule for teaching anesthesiologists to the single resident case (which is not concurrent to any other case) or the two concurrent resident cases (which are not concurrent to any other cases). For the mixed concurrent case, we could continue to apply our current medical direction payment policy to both the resident case and the other concurrent case. This would represent a continuation of our current medical direction payment policy, and would be predicated on the assumption that this is consistent with Congressional intent since the medical direction payment provisions at section 1848(a)(4) of the Act were left largely unchanged by section 139(a) of the MIPPA.

The other option would be to apply the special payment rule for teaching

anesthesiologists to the resident case when it is concurrent to a medically directed case, and to apply the medical direction payment policy to the medically directed case. While this represents a broader interpretation, it still limits the applicability of the special payment rule for teaching anesthesiologists to resident cases consistent with the terms of section 139 of the MIPPA.

The special payment rule under section 1848(a)(6) of the Act clearly applies for two concurrent anesthesia resident cases. The ACGME requirements also allow the supervision of two concurrent cases, but are not specific regarding whether the requirements relate only to two resident cases, or also to mixed concurrent cases. However, both the statute and ACGME requirements seem amenable to a policy that would allow the special teaching payment rule to apply in mixed concurrent cases, that is, the single resident case that is concurrent to another case not involving a resident. Additionally, we are concerned that if we continued to apply the medical direction payment policy to mixed concurrent cases, then financial differences in payment policy might cause teaching anesthesiologists to make changes in the scheduling of mixed resident and CRNA cases. This might limit the utilization of CRNAs in certain scenarios.

Accordingly, we are proposing to delete the current regulatory language at § 414.46(e) (which is no longer relevant) and add new language to specify that the special payment rule for teaching anesthesiologists applies to resident cases under the following scenarios:

- The teaching anesthesiologist is involved in one resident case (which is not concurrent to any other anesthesia case);
- The teaching anesthesiologist is involved in each of two concurrent resident cases (which are not concurrent to any other anesthesia case); or
- The teaching anesthesiologist is involved in one resident case that is concurrent to another case paid under medical direction payment rules.

Other than the application of the special payment rule for teaching anesthesiologists in the mixed concurrent case described above, we are not proposing any other revisions to our medical direction payment policies.

b. Teaching Anesthesiologists: Criteria for Payment

(1) Criteria for Payment of Teaching Anesthesiologists

Currently, the teaching anesthesiologist can be paid at the regular fee schedule rate for his or her involvement in a single resident case. As specified in § 415.178, the teaching anesthesiologist must be present with the anesthesia resident during all critical portions of the anesthesia procedure and be immediately available to furnish services during the entire procedure. Our manual instructions permit different physicians in the same anesthesia group to provide parts of the anesthesia service, and for the group to bill for the single anesthesia service. We refer to this practice as an ''anesthesia handoff.'' (*See* Medicare Claims Processing Manual 100–04, Chapter 12, Section 50 C.) Of course, the medical record must document those individual physicians who furnished the services.

This manual instruction is not limited in scope to nonteaching hospitals. Thus, it is possible that teaching anesthesiologists have interpreted it to permit handoffs during resident cases.

Our manual instructions state that for two overlapping surgeries, the teaching surgeon must be present during the critical or key portions of both operations (*See* Medicare Claims Processing Manual 100–04, Chapter 12, Section 100.1.2). It is our understanding that teaching surgeons do not hand off to another teaching surgeon during a key or critical portion of the surgical resident case.

(2) Section 139(a)(2) of the MIPPA

This section adds a new paragraph at section 1848(a)(6) of the Act which requires, in order for the special payment rule for teaching anesthesiologists to apply, that the teaching anesthesiologist is present during all critical or key portions of the anesthesia service or procedure and the teaching anesthesiologist (or another anesthesiologist with whom the teaching anesthesiologist has entered into an arrangement) is immediately available to furnish anesthesia services during the entire procedure. The new MIPPA provision regarding payment for services of a teaching anesthesiologist for two concurrent resident cases is similar to our current policy regarding payment for services of a teaching surgeon for two overlapping surgical resident cases.

(3) Discussion

The ASA has informed us that teaching anesthesiologists who work in the same anesthesia group sometimes provide different parts of the key or critical portions of a single anesthesia procedure. This type of a handoff situation might occur within an anesthesia group practice when there is an anesthesia procedure of long duration, but would not be limited to that circumstance.

From a quality standpoint, we do not believe multiple handoffs among teaching anesthesiologists during a case that involves the training of an anesthesia resident would be optimal. We do not have data on the extent to which anesthesia handoffs occur during resident or other cases, or whether quality of anesthesia care is affected. We note that section 1848(a)(6)(A) of the Act refers only to ''the'' teaching anesthesiologist, and requires that the teaching anesthesiologist be present during all critical or key portions of the service. However, section 1848(a)(6)(B) of the Act seems to contemplate some level of handoffs between teaching anesthesiologists, at least between those who have entered into an arrangement for such handoffs.

One option would be to permit different anesthesiologists in the same anesthesia group practice to be considered ''the teaching physician'' for purposes of being present at the key or critical portions of the anesthesia case. (These physicians must have reassigned their benefits to the group practice in order for the group to bill.) Although this option would be less disruptive to the current anesthesia practice arrangements (as reported by the ASA), it would establish rules for teaching anesthesiologists that are different from those for teaching surgeons.

Another option would be to require that, in order to meet the requirement of section 1848(a)(6)(A) of the Act, only one individual teaching anesthesiologist must be present during all of the key or critical portions of the procedure. However, another teaching anesthesiologist with whom ''the teaching anesthesiologist'' under subparagraph (A) has an arrangement could be immediately available to furnish services during a non-critical or non-key portion of the procedure in order to meet the requirement under subparagraph (B). We believe this is the most logical reading of the statute and would be consistent with the way the teaching surgeon payment policy is applied for overlapping surgical cases.

In addition to explaining available options for implementing this provision, we are also soliciting specific comments on how the continuity of care and the quality of anesthesia care are preserved during handoffs. We are interested in whether there is an accepted maximum number of handoffs and whether there are any industry studies that have examined this issue. We would like to hear from anesthesia practices that do not use handoffs and what procedures they have implemented to achieve this

result. Finally, we would like to know what factors or variables are contributing to anesthesia handoffs and what short term adjustments can be made to affect these factors.

Although we are interested in receiving comments on these topics, we are proposing to more narrowly interpret the law and require that only one individual teaching anesthesiologist be present during all of the key or critical portions of the anesthesia procedure. We are also proposing that another teaching anesthesiologist with whom the teaching anesthesiologist has an arrangement could be immediately available to furnish services during a non-critical or non-key portion of the procedure.

c. Teaching CRNAs

(1) Payment for Anesthesia Services Furnished by a CRNA

Currently, a CRNA who provides anesthesia services while under the medical direction of an anesthesiologist is paid at 50 percent of the regular fee schedule rate as specified in section 1833(l)(4)(B)(iii) of the Act. A CRNA who provides anesthesia services without the medical direction of a physician is paid the regular fee schedule rate as specified in section 1833(l)(4)(A) of the Act.

(2) Payment for Anesthesia Services Furnished by a Teaching CRNA With a Student Nurse Anesthetist

The legislation that created the CRNA fee schedule payment system (that is, section 9320 of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99–509)) did not address payment for services furnished by teaching CRNAs involved in the training of student nurse anesthetists.

In the preamble to the CRNA fee schedule final rule published in the July 31, 1992 **Federal Register** (57 FR 33888), we stated that we would pay the teaching CRNA who is not medically directed by a physician at the regular fee schedule rate for his or her involvement in a single case with a student nurse anesthetist as long as he or she was present with the student throughout the anesthesia case. No payment would be made if the teaching CRNA divided his or her time between two concurrent cases involving student nurse anesthetists.

In August 2002, based on the recommendations of the American Association of Nurse Anesthetists (AANA), we modified our policy to allow the teaching CRNA not medically directed by a physician to be paid a portion of the regular fee schedule rate for each of two concurrent cases involving student nurse anesthetists. If the teaching CRNA is present with the student nurse anesthetist during the pre- and post-anesthesia care for each of the cases involving student nurse anesthetists, the teaching CRNA can bill the full base units (comprised of pre- and post-anesthesia services not included in the anesthesia time units) for each case and the actual amount of anesthesia time per case. The resulting payment for each of these anesthesia cases is greater than 50 percent, but less than 100 percent, of the regular fee schedule amount because the full base units plus the actual anesthesia time units spent by the teaching CRNA in each of the two cases yields a payment that is greater than 50 percent of the regular fee schedule amount.

(3) Comparison of Payment Policies for Teaching CRNAs and Teaching Anesthesiologists

For several years, the American Society of Anesthesiologists (ASA) requested that we revise our payment regulations to allow the teaching anesthesiologist to be paid the regular fee schedule amount for each of two concurrent resident cases. In the CY 2004 PFS final rule with comment period (68 FR 63224), we finalized a policy to permit the teaching anesthesiologist to be paid similarly to a teaching CRNA for each of two concurrent resident cases. This policy took effect for services furnished on or after January 1, 2004.

Thus, the payment policy is the same for a teaching CRNA for each of two concurrent student nurse anesthetist cases, and for a teaching anesthesiologist for each of two concurrent resident cases. The policy is that the anesthesia provider is paid the full base units plus time units, based on the actual anesthesia time, relating to each of two concurrent cases.

(4) Payment Policy for an Anesthesiologist, or an Anesthesiologist and CRNA Jointly, With a Student Nurse Anesthetist

Currently, there are circumstances where an anesthesiologist may be involved in the training of student nurse anesthetists in two concurrent anesthesia cases. These anesthesia cases are not paid under the teaching anesthesiologist payment policy, but are paid under the usual medical direction payment policy. Payment can be made for the physician's medical direction (that is, 50 percent of the regular fee schedule amount) for each of two concurrent cases.

If an anesthesiologist is medically directing two concurrent cases involving student nurse anesthetists and a CRNA is also jointly involved with the two student nurse anesthetist cases, then the physician service, in each case, can be paid under the medical direction rules at 50 percent of the regular fee schedule. Payment for the CRNA services would also be made at the medically directed rate (that is, 50 percent of the regular fee schedule) for CRNA services, but the time units used to compute the anesthesia fee would be based on the actual time the CRNA is involved in each case.

(5) Section 139(b) of the MIPPA

Section 139(b) of the MIPPA instructs the Secretary to make appropriate adjustments to Medicare teaching CRNA payment policy so that it—

- Is consistent with the adjustments made by the special payment rule for teaching anesthesiologists under section 139(a) of the MIPPA; and
- Maintains the existing payment differences between teaching anesthesiologists and teaching CRNAs.

We are proposing to implement the first directive (under section 139(b)(1) of the MIPPA) by establishing a new payment policy for teaching CRNAs that is similar to the special payment rule for teaching anesthesiologists, and to limit applicability of the rule to teaching CRNAs who are not medically directed. We are proposing to add a new regulation at § 414.61 to explain the conditions under which the special payment rule will apply and the method for calculating the amount of payment for anesthesia services furnished on or after January 1, 2010, by teaching CRNAs involved in the training of student nurse anesthetists. Under this proposal, we would pay the teaching CRNA at the regular fee schedule rate for each of two concurrent student nurse anesthetist cases. Our medical direction payment policy would continue to apply if both an anesthesiologist and a CRNA are involved in a student nurse anesthetist case that is concurrent to other anesthesia cases.

We believe the second directive in section 139(b)(2) of the MIPPA will be satisfied as a result of these proposals. Section 139(b)(1) of the MIPPA instructs CMS to make appropriate adjustments to implement a payment policy for teaching CRNAs that is consistent with the special payment rule for teaching anesthesiologists. Section 139(b)(2) of the MIPPA instructs CMS to maintain the existing payment differences between teaching anesthesiologists and teaching CRNAs. There currently are no substantive differences in payment

between teaching anesthesiologists and teaching CRNAs, and there would continue to be no such differences under our proposed policies.

(6) Payment for Teaching CRNAs Involved in Anesthesia Cases With Student Nurse Anesthetists

Under current policy, when a CRNA is involved in a single student nurse anesthetist case, the teaching CRNA must be present with the student throughout the case in order to be paid at the regular fee schedule rate. We are not proposing any change to this policy.

When the teaching CRNA is involved in two concurrent student nurse anesthetist cases, payment is based on the amount of anesthesia time the teaching CRNA spends with the student in each case. For example, if the teaching CRNA spends 40 percent of his or her time in concurrent case #1 and 60 percent of his or her time in concurrent case #2, and the total anesthesia time in both cases is 3 hours (or 180 minutes), then we would currently pay as follows:

- Case #1: (Base units + (0.4 × 180/15)) × Anesthesia CF
- Case #2: (Base units + (0.6 × 180/15)) × Anesthesia CF

The current payment policy has been predicated on paying the teaching CRNA for his or her actual time spent in the student nurse anesthetist case. We are now proposing to pay the teaching CRNA at the regular fee schedule rate for his or her involvement in two concurrent cases. If our goal is to minimize the effect of this change on teaching CRNAs' practice arrangements and time devoted to cases, then we would propose that the teaching CRNA continue to devote 100 percent of his or her time to the two concurrent cases. The teaching CRNA would decide how to allocate his or her time to optimize patient care in the two cases based on the complexity of the anesthesia case, the experience and skills of the student nurse anesthetist, the patient's health status, and other factors.

An alternative to this policy would be to apply the same criteria for teaching CRNAs as we use in § 415.178 with respect to teaching anesthesiologists. These criteria require the teaching anesthesiologist to be present during all critical or key portions of the anesthesia service. However, we believe these criteria are relevant and appropriate only for teaching anesthesiologists due to significant differences in experience, education and other qualifications between anesthesia residents and student nurse anesthetists. The anesthesia resident has completed medical school and is typically a licensed physician. In contrast, the student nurse anesthetist is an RN who usually has some clinical experience in ICU or critical care nursing prior to starting the CRNA training program. Thus, we believe the resident is more qualified through medical training and education than the student nurse anesthetist to provide elements of the anesthesia service without the immediate presence of the teaching anesthesiologist. Therefore, we propose to retain our current policy.

We note that the Congress did not amend the statutory provisions relating to medical direction at section 1848(a)(4) of the Act. We do not believe the directives at section 139(b) of the MIPPA extend to other arrangements in which anesthesiologists alone or both anesthesiologists and CRNAs jointly supervise student nurse anesthetists during concurrent anesthesia cases. Therefore, we are not proposing any changes to our current payment policies for anesthesia services furnished under other circumstances. We are proposing that when an anesthesia provider (physician or CRNA) furnishes anesthesia services in concurrent cases under other circumstances, the current policies regarding medical direction will continue to apply.

8. Section 144(a): Payment and Coverage Improvements for Patients With Chronic Obstructive Pulmonary Disease and Other Conditions—Cardiac Rehabilitation Services

Section 144(a) of the MIPPA amended Title XVIII of the Act, in pertinent part, to provide for coverage of cardiac rehabilitation (CR) and intensive cardiac rehabilitation (ICR) under Medicare Part B. The statute specifies certain conditions for these services, with coverage to begin on January 1, 2010. The addition of the new CR and ICR programs is designed to improve the health care of Medicare beneficiaries with cardiovascular disease. This proposed rule implements these MIPPA provisions in order to ensure services enhance the patient's clinical outcomes.

a. Background

Intensive cardiac rehabilitation (ICR) is a relatively new practice that is also commonly referred to as a ''lifestyle modification'' program. These programs typically involve the same elements as general CR programs, but are furnished in highly structured environments in which sessions of the various components may be combined for longer periods of CR and also may be more rigorous.

b. Cardiac Rehabilitation Coverage Under Medicare

One mechanism we use to establish coverage for certain items and services is the national coverage determination (NCD) process. An NCD is a determination by the Secretary with respect to whether or not a particular item or service is covered nationally under Title XVIII.

Since 1982, Medicare has covered, under an NCD, cardiac rehabilitation for patients who experience stable angina, have had coronary artery bypass grafts, or have had an acute myocardial infarction within the past 12 months. The NCD is located in the Medicare NCD Manual (Pub. 100–03), section 20.10. Effective March 22, 2006, we modified the NCD language to cover comprehensive cardiac rehabilitation programs for patients who experience one of the following:

- A documented diagnosis of acute myocardial infarction within the preceding 12 months.
- A coronary bypass surgery.
- Stable angina pectoris.
- A heart valve repair/replacement.
- A percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting.
- A heart or heart-lung transplant.

Comprehensive programs must include a medical evaluation, a program to modify cardiac risk factors, prescribed exercise, education, and counseling and may last for up to 36 sessions over 18 weeks or no more than 72 sessions over 36 weeks if determined appropriate by the local Medicare contractors. Facilities furnishing cardiac rehabilitation must have immediately available necessary cardio-pulmonary, emergency, diagnostic, and therapeutic life-saving equipment and be staffed with personnel necessary to conduct the program safely and effectively who are trained in advanced life support techniques and exercise therapy for coronary disease. The program must also be under the direct supervision of a physician. Until section 144(a) of the MIPPA is effective, ICR programs are covered under this NCD and are subject to the same coverage requirements.

We are proposing to implement section 144(a) of the MIPPA and refine coverage for CR and ICR through this rulemaking process. When the rulemaking is completed, we will take the necessary steps to withdraw and/or modify the NCD.

c. Statutory Authority

Section 144(a) of the MIPPA amended the Medicare Part B program by adding new sections 1861(s)(2)(CC) and

1861(s)(2)(DD) of the Act to include items and services furnished under a ''cardiac rehabilitation program'' and an ''intensive cardiac rehabilitation program,'' respectively. A cardiac rehabilitation program is defined in new section 1861(eee)(1) of the Act and an intensive cardiac rehabilitation program is defined in new section 1861(eee)(4)(A) of the Act.

A cardiac rehabilitation program is a physician-supervised program that furnishes the following: Physician-prescribed exercise; cardiac risk factor modification, including education, counseling, and behavioral intervention; psychosocial assessment; outcomes assessment; and other items or services as determined by the Secretary under certain conditions. These items and services must be furnished in a physician's office, in a hospital on an outpatient basis, or in other settings as determined appropriate by the Secretary. A physician must be immediately available and accessible for medical consultation and emergencies at all times items and services are being furnished in a CR program except when provided in a hospital setting where such availability is presumed. The items and services furnished by a CR program are individualized and set forth in written treatment plans that describe the patient's individual diagnosis; the type, amount, frequency, and duration of items and services furnished under the plan; and the goals set for the individual under the plan. These written plans must be established, reviewed, and signed by a physician every 30 days.

We are proposing that ICR programs must provide the same items and services under the same conditions as CR programs but must demonstrate, as shown in peer-reviewed published research, that they have accomplished one or more of the following: Positively affected the progression of coronary heart disease, or reduced the need for coronary bypass surgery, or reduced the need for percutaneous coronary interventions (PCIs). The peer-reviewed published research must also show that the ICR program has resulted in a statistically significant reduction in 5 or more measures from their levels before ICR services to their levels after receipt of such services. These measures include low density lipoprotein; triglycerides; body mass index; systolic blood pressure; diastolic blood pressure; or the need for cholesterol, blood pressure, and diabetes medications.

Beneficiaries eligible for ICR must have experienced the following: An acute myocardial infarction within the preceding 12 months; a coronary bypass surgery; current stable angina pectoris; a heart valve repair or replacement; a PTCA or coronary stenting; or a heart or heart-lung transplant. Section 1861(eee)(4)(C) of the Act, as added by section 144(a)(1)(B) of the MIPPA, states that an ICR program may be provided in a series of 72, 1-hour sessions (as defined in section 1848(b)(5) of the Act), up to 6 sessions per day, over a period of up to 18 weeks.

The statute directs the Secretary to establish standards for the physician(s) supervising the ICR and/or CR programs to ensure that the physician has expertise in the management of individuals with cardiac pathophysiology and is licensed by the State in which the CR program (or ICR program) is offered. These standards ensure that the physician is responsible for the program and, in consultation with appropriate staff, is involved substantially in directing the progress of individuals in the program.

d. Proposals for Implementation

We are proposing to create new § 410.49, ''Cardiac Rehabilitation Program and Intensive Cardiac Rehabilitation Program: Conditions of Coverage.''

(1) Definitions

In this section, we are proposing several definitions for the terms used with respect to the programs and services required by section 144(a) of the MIPPA. These terms include the following:

- Cardiac rehabilitation program.
- Individualized treatment plan.
- Intensive cardiac rehabilitation.
- Physician.
- Physician-prescribed exercise
- Psychosocial assessment.
- Outcomes assessment.

(2) Covered Beneficiaries

In § 410.49, we are proposing to establish coverage for CR and ICR programs for beneficiaries who have experienced any of the following: An acute myocardial infarction within the preceding 12 months; a coronary bypass surgery; current stable angina pectoris; a heart valve repair or replacement; a PTCA or coronary stenting; or a heart or heart-lung transplant. We are proposing to maintain and refine coverage of general CR programs for beneficiaries with these six conditions as originally established in Pub. 100–03, section 20.10 as this coverage was determined to be reasonable and necessary under section 1862(a)(1)(A) of the Act due to a high level of supporting clinical evidence. We are also proposing through this rulemaking to use the NCD process in the future to identify additional medical indications for patients who could obtain CR under Medicare Part B. While CR programs include certain mandatory services, the written plans are highly individualized, and we propose to allow some flexibility in the type, amount, frequency, and duration of services provided in each session. However, as supported by medical literature and statements of the American Heart Association (AHA) and the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR),[4] aerobic exercise training using the muscles of ambulation is a mandatory component of any CR or ICR program. We recommend both low- and high-intensity exercise to produce optimal benefits, and suggest a combination of endurance, strengthening and stretching exercises. Patients in general CR programs must participate in a minimum of 2, 1-hour CR sessions a week, and a maximum of 2, 1-hour sessions a day. Patients in ICR programs may participate in up to 6, 1-hour sessions per day not to exceed 72, 1-hour sessions over an 18-week period. By a 1-hour session, we mean that each session must last a minimum of 60 minutes. Each day CR or ICR items and services are provided to a patient, aerobic exercises along with other exercises must be included (that is, a patient must exercise aerobically every day he or she attends a CR or ICR session). Exercise may include the use of treadmills, bicycles, light weights or other equipment, and should be intended to improve cardiovascular function, strength, endurance, and flexibility.

Section 144(a) of the MIPPA requires CR and ICR programs to furnish items and services including ''cardiac risk factor modification.'' This includes education, counseling, and behavioral intervention to the extent these services are closely related to the individual's care and treatment and tailored to patients' individual needs. We are proposing that patients must be provided with the information and tools to improve their overall cardiovascular health. Items and services furnished as part of the risk factor modification component should be highly

[4] Balady G, Williams M, Ades P, et al. Core Components of Cardiac Rehabilitation/Secondary Prevention Programs: 2007 Update. A Scientific Statement From the American Heart Association Exercise, Cardiac Rehabilitation, and Prevention Committee, the Council on Clinical Cardiology; the Councils on Cardiovascular Nursing, Epidemiology and Prevention, and Nutrition, Physical Activity, and Metabolism; and the American Association of Cardiovascular and Pulmonary Rehabilitation. *Journal of Cardiopulmonary Rehabilitation and Prevention* 2007;27:121–129.

individualized as multiple risk factors contribute to poor cardiovascular health. For example, these items and services may include smoking cessation counseling or referral, nutritional education and meal planning, stress management, prescription drug education and management information, disease history education in order to foster a better understanding of disease origins and disease symptomatology, and any other education, counseling and behavioral intervention deemed appropriate in each patient's individualized treatment plan.

The MIPPA provisions require a psychosocial assessment as part of the CR and ICR programs defined above. We are proposing that the initial assessment by program staff evaluate aspects of the individual's family and home situation that may affect their treatment, and consider at the outset if referrals to support groups, community and/or home care services are necessary. Prior to each 30-day review of the individualized treatment plan, the supervising physician or program staff will conduct an evaluation of the individual's response to, and rate of progress under, the treatment plan and make recommendations to the physician as necessary. While the individualized treatment plan discussed below will assist in ensuring that patients begin CR with a program tailored to their needs, a periodic re-evaluation is necessary to ensure that their psychosocial needs are in fact being met.

The MIPPA provisions also require that CR and ICR programs include outcomes assessment. Professional groups, such as the AHA and AACVPR, recognize a number of relevant patient outcomes that may be expected to accrue from the various components of cardiac rehabilitation.[5] We propose to define outcomes assessment as an evaluation of the patient's progress in the program using assessments from the commencement and conclusion of CR and ICR programs that are based upon patient centered outcomes. Patient centered outcomes must be measured at the beginning of the CR program, prior to each 30-day review of the individualized treatment plan, and at the end of the CR program. All assessments are considered part of the CR program and, as such, are conducted in the appropriate settings and not billed separately. These measures should include resting and exercising heart rate, resting and exercising systolic and diastolic blood pressure, weight, BMI, amount and dosage of medications required, self-reported quality of life, and behavioral measures (for example, smoking cessation, increased activity levels, change in exercise levels during CR). As CR programs must be highly individualized, alternate or additional measures may be appropriate. Patients' individualized treatment plans should be altered accordingly with changes and/or progress in each of the outcome measurements. Programs may also develop performance standards which measure the overall quality of the program, by assessing the group as a whole.

The MIPPA provisions require that CR services be provided under written individualized treatment plans. As CR programs are highly individualized, we propose that the physician define and set the parameters, including the individual's diagnosis, the types of services appropriate, and the treatment goals. The MIPPA provisions require the physician to establish the written individualized treatment plan and conduct subsequent reviews every 30 days. This plan may initially be developed by the referring physician or the CR physician. If the plan is developed by the referring physician who is not the CR physician, the CR physician must also review and sign the plan prior to initiation of CR. Direct physician contact is not always required to meet the 30-day review standards, but might be necessary depending upon specific patient factors. Regardless, CR staff must provide both outcome and psychosocial assessments to the supervising physician prior to the 30-day deadline and the physician must evaluate the information provided by the CR staff. The CR staff may make recommendations for modifications to the program, but the physician will still modify the plan as needed, and review and sign the plan. The MIPPA provisions require written specificity relating to the type, amount, frequency, and duration of the items and services furnished under the individual's plan. As CR patients have had or may develop disabling cardiovascular disease, they require individual attention and assessments that address their individualized needs and meet realistic individualized goals through a specifically designed treatment plan. The individualized treatment plan should specify the combination of services necessary to address the patient's needs, as identified through the initial assessment and based upon changes in the patient's condition. It must include measurable and expected outcomes and estimated timetables to achieve these outcomes. The outcomes specified in the individualized treatment plan should be consistent with current evidence-based professionally-accepted clinical practice standards such as those identified by the AHA and AACVPR.

The MIPPA provisions also authorize the Secretary to include other mandatory items and services within the scope of the CR program under certain conditions. We are not proposing to require any other items and services at the present time. If the Secretary determines that the addition of any other items and services is appropriate, additions will be made and implemented through future rulemaking.

Section 144(a) of the MIPPA provides for coverage of CR and ICR services in various settings which include a physician's office, a hospital on an outpatient basis or other settings determined appropriate by the Secretary. We are not proposing to cover CR or ICR in other settings at this time. If the Secretary determines that the addition of settings is appropriate, additions will be made through rulemaking. All settings should have all equipment and staff necessary, consistent with cardiac rehabilitation professional society recommendations, to provide statutorily-mandated items and services.

Section 144 of the MIPPA includes requirements for immediate and ongoing physician availability and accessibility for both medical consultations and medical emergencies at all times items and services are being furnished under the program. Professional groups such as the AHA and AACVPR recognize the need to provide appropriate patient supervision and, where appropriate, monitoring. We are proposing that such availability be met through existing definitions for direct physician supervision in physician offices and hospital outpatient departments at § 410.26(a)(2) (defined through cross reference to § 410.32(b)(3)(ii)) and § 410.27(f), respectively. Direct supervision, as defined in the regulations, is consistent with the language of the MIPPA because the physician must be present and immediately available where the services are being furnished. The physician must also be able to furnish

[5] Balady G, Williams M, Ades P, et al. Core Components of Cardiac Rehabilitation/Secondary Prevention Programs: 2007 Update. A Scientific Statement From the American Heart Association Exercise, Cardiac Rehabilitation, and Prevention Committee, the Council on Clinical Cardiology; the Councils on Cardiovascular Nursing, Epidemiology and Prevention, and Nutrition, Physical Activity, and Metabolism; and the American Association of Cardiovascular and Pulmonary Rehabilitation. *Journal of Cardiopulmonary Rehabilitation and Prevention* 2007;27:121–129.

assistance and direction throughout the performance of the services, which would include medical consultations and medical emergencies.

For CR and ICR services provided in physicians' offices and other Part B settings paid under the PFS, the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the service or procedure in accordance with the § 410.26(b)(5). This does not mean that the physician must be in the room when the service or procedure is performed. For CR and ICR services provided to hospital outpatients, direct physician supervision is the standard set forth in the April 7, 2000 OPPS final rule with comment period (68 FR 18524 through 18526) for supervision of hospital outpatient therapeutic services covered and paid by Medicare in hospitals and provider-based departments of hospitals. We currently define and specify the requirement for direct supervision for services furnished in provider-based departments of hospitals at § 410.27(f). For this purpose, the physician must be on the premises of the location (meaning the provider-based department) and immediately available to furnish assistance and direction throughout the performance of the procedure. This does not mean that the physician must be present in the room when the procedure is furnished. If we were to propose future changes to the physician office or hospital outpatient policies for direct physician supervision, we would provide our assessment of the implications of those proposals for the supervision of cardiac rehabilitation services at that time.

The MIPPA provisions state that in the case of items and services furnished under such a program in a hospital, physician availability shall be presumed. As we have stated in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68702 through 68704), the longstanding presumption relating to direct physician supervision for hospital outpatient services means that direct physician supervision is the standard for supervision of hospital outpatient therapeutic services covered and paid by Medicare in hospitals and provider-based departments of hospitals, and we expect that hospitals are providing services in accordance with this standard.

New section 1861(eee)(4) of the Act requires ICR programs, to be qualified for Medicare coverage, to meet several standards. To become qualified, an ICR program must demonstrate through peer-reviewed, published research that it has accomplished one or more of the following: (1) Positively affected the progression of coronary heart disease; (2) reduced the need for coronary bypass surgery; or (3) reduced the need for percutaneous coronary interventions (PCIs). A qualified ICR program must also demonstrate through peer-reviewed published research that the ICR program accomplished a statistically significant reduction for patients in 5 or more specific measures from the individual's levels before ICR services to their levels after receipt of such services. These measures include: (1) Low density lipoproteins; (2) triglycerides; (3) body mass index; (4) systolic blood pressure; (5) diastolic blood pressure; and (6) the need for cholesterol, blood pressure, and diabetes medications. To ensure that ICR programs in fact meet these standards, we are proposing that programs intending to operate as ICR programs apply to CMS to receive designation as qualified ICR programs. Only designated programs would then be eligible for Medicare coverage and would be required to undergo regular re-evaluation to maintain such status. We are requesting public comments on establishing an annual re-evaluation process.

We are proposing that programs may apply to CMS to be designated qualified programs to provide ICR. To meet this designation, programs must submit to CMS detailed literature describing the program and the precise manner in which the program meets MIPPA provisions. Each program must also submit peer-reviewed, published research specific to the actual program applying for approval. The research must clearly demonstrate that the program under examination accomplishes at least the minimum outcomes as defined above. We are proposing, based on our general rulemaking authority that each ICR program must submit a detailed description of the items and services available to ICR patients and the capabilities of the facility in which the program takes place as well as the responsibilities of program staff. All materials shall be submitted to: Director, Coverage and Analysis Group, Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Mail Stop C1–09–06, Baltimore, Maryland 21244.

Following CMS review, ICR programs will either be notified of any missing information or inadequacies in their submissions (so they may resubmit in the future) or be notified of CMS designation as an ICR program. Designated programs will be identified in a list of ICR programs posted on the CMS Web site and in the **Federal Register**. We are proposing that all designated programs must demonstrate continued compliance with MIPPA standards every year in order to maintain qualified status.

We are proposing that for an ICR program to maintain its designation by CMS as a qualified ICR program, the program must submit specific outcomes assessment information. Programs shall submit information for all patients who initiated and completed the full ICR program during the initial year-long CMS designation. For each patient, programs must identify the following: (1) The medical condition qualifying the patient for eligibility to participate in ICR; (2) the patient's improvement in coronary heart disease, reduced need for coronary bypass surgery, and/or reduced need for PCIs; and (3) the levels of the 5 or more measures identified above at the beginning and end of the program. Programs must also submit average beginning and ending levels of at least those 5 measures for the program as a whole. If any changes are made to the ICR program during the initial year-long CMS designation, such changes must be documented and submitted with the outcomes assessment information. Programs will have 30 days to submit this information to CMS following the end of the initial approval period. In the month following receipt, we will review the submitted information and determine whether the program continues to meet the payment standards. We believe that re-evaluations of designated programs will assist CMS in ensuring that programs continue to demonstrate the outcome measures identified for initial designation. We are requesting public comments on annual program re-evaluations requirements, the required information for re-evaluation proposed above and if an administrative appeals process should be established for ICR programs that no longer meet outcomes standards. We are also asking for public comments on the time period for re-evaluations of ICR programs.

Section 144(a)(1)(B) of the MIPPA requires CR and ICR programs to be physician-supervised. In addition, section 144(a)(5) of the MIPPA requires the Secretary to establish standards to ensure that the physician, who has the appropriate expertise in the management of individuals with cardiac pathophysiology and is licensed to practice medicine in the State in which the CR or ICR program is offered, is responsible for the CR or ICR program. We propose to identify this physician who oversees or supervises the CR and ICR program in its entirety as the Medical Director. As required by

144(a)(5), we are proposing that the Medical Director must have training and proficiency in cardiovascular disease management and exercise training of heart disease patients. We also propose that the Medical Director, in consultation with other staff, must be involved substantially in directing the progress of individuals in the program. We are expressly seeking public comments on the precise level of expertise that is necessary for the Medical Director.

As discussed above, section 144(a)(2)(B) of MIPAA requires that a physician must be immediately available and accessible for medical consultations and medical emergencies at all times items and services are being furnished under the program. For purposes of this proposed rule we are identifying this physician as the supervising physician (that is, the physician that must be immediately available to furnish assistance and direction throughout the performance of CR and ICR services); we believe this physician also requires expertise in cardiac pathophysiology resulting from training or experience in cardiovascular disease management and exercise training of heart disease patients. This includes a physician billing Medicare Part B for providing services directly to a patient during a CR or ICR session. We are proposing standards for these physicians based on our general rulemaking authority which include expertise in the management of individuals with cardiac pathophysiology and licensure to practice medicine in the State in which the CR or ICR program is offered. We are expressly inviting public comments about the precise level of expertise that is necessary.

Please note that the program Medical Director may fulfill both roles of Medical Director and supervising physician (of individual CR and ICR services furnished to patients) provided that the requirements for direct physician supervision as required in §§ 410.26 and 410.27 are met when CR or ICR items and services are furnished, as discussed above.

We are requesting public comments regarding whether specific training and expertise standards are needed for the cardiac rehabilitation staff.

Section 1861(eee)(4)(C) of the Act provides for coverage of ICR programs that are provided in a series of 72 1-hour sessions (as defined in section 1848(b)(5) of the Act), up to 6 sessions per day, over a period of up to 18 weeks. Specific provisions for the number, duration, and time period for general CR programs are not identified in the MIPPA; however we propose to maintain, with slight refinements, coverage requirements previously established in Pub. L. 100–03, section 20.10 through this rulemaking process. For eligible beneficiaries, general CR is provided for up to 36 1-hour sessions, up to 2 sessions per day with no fewer than 2 sessions per week, over up to 18 weeks, with contractor discretion to expand these limitations to not exceed 72 sessions for 36 weeks. This is based on section 1862(a)(1)(A) of the Act and our general rulemaking authority. By 1-hour session, we mean that each session must last a minimum of 60 minutes.

e. Coding and Payment

(1) CR Payment

Currently, the following CPT codes are used for CR services described in section 144(a) of the MIPPA: CPT code 93797, *Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)*; and CPT code 93798, *Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)*. We are not proposing to revise these codes under the PFS because the CR program authorized by the existing NCD is essentially the same as that included in the MIPPA.

(2) ICR Payment

The statute requires that the hospital Outpatient Prospective Payment System (OPPS) payment amount for CR services be substituted for ICR under the PFS, specifically the payment for CPT codes 93797 and 93798 or any succeeding HCPCS codes for CR. We are proposing to create two new HCPCS codes for ICR services. These codes may only be billed by ICR programs that have been approved by CMS. The proposed codes are as follows:

- GXX28, *Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session*.
- GXX29, *Intensive cardiac rehabilitation; with or without continuous ECG monitoring; without exercise, per session*.

These HCPCS codes will be recognized under the PFS and the OPPS. Under the OPPS the existing CR HCPCS codes, CPT codes 93797 and 93798, are assigned to APC 0095 (Cardiac Rehabilitation) for CY 2009. Because the payment under the PFS for the two proposed ICR G-codes is required to be the same as the payment for CR services under OPPS, we are proposing to pay the same amount as will be established through rulemaking for CY 2010. The proposed OPPS payment amount for CR services will be announced in the CY 2010 OPPS/ASC proposed rule. We are proposing that this amount will be adjusted for the appropriate locality by applying the GPCI under the PFS. The CY 2010 proposed APC assignments and payment rates for these two ICR G-codes will be published in the CY 2010 OPPS/ASC proposed rule. The proposed payment rate for the associated APC(s) will be included in Addendum A to the CY 2010 OPPS/ASC proposed rule.

We note that when a CR/ICR service is furnished in a hospital outpatient department, a physician cannot bill the Medicare contractor for CR/ICR unless the physician personally performs the CR/ICR service. To personally perform the CR/ICR service, the physician would provide direct care to a single patient for the entire session of CR/ICR that is being reported. In this case, the hospital would report the CR/ICR service and be paid the OPPS payment for the facility services associated with the CR/ICR session and the physician would report and be paid the PFS amount for the CR/ICR service. A physician cannot bill under the PFS for CR/ICR services furnished in a hospital for which the physician furnishes only supervision or for services furnished in part by others. If the physician furnishes no direct CR/ICR services for a given session or on a given day or provides direct CR/ICR services for less than the full session, then only the hospital would report the CR/ICR services and these services would be paid under the OPPS.

9. Section 144(a): Payment and Coverage Improvements for Patients With Chronic Obstructive Pulmonary Disease and Other Conditions—Pulmonary Rehabilitation Services

Section 144 of the MIPPA amended Title XVIII of the Act to provide for coverage of pulmonary rehabilitation (PR) under Part B, under certain conditions, for services furnished on or after January 1, 2010. This proposed rule would implement the new Medicare pulmonary rehabilitation program and establish the requirements for providing such services to Medicare beneficiaries with a diagnosis of moderate to severe chronic obstructive pulmonary disease (COPD). COPD is not only one of the more common of the diseases in the category of chronic respiratory diseases, it is one of the more severely debilitating, characterized by chronic bronchitis and emphysema. Other diseases and conditions in this category include persistent asthma, bronchiectasis, primary pulmonary hypertension, obesity-related respiratory

disease, and ventilator dependency. This rule provides direction in implementing the MIPPA in order to ensure services are covered and enhance the patient's clinical outcomes.

a. Background

A PR program is typically a multidisciplinary program of care for patients with chronic respiratory impairment that is individually tailored and designed to optimize physical and social performance and autonomy. The main goal of an individualized PR training program is to empower and facilitate the individuals' ability to exercise independently; exercise is the cornerstone of the PR program. Exercise is combined with other training and support mechanisms necessary to integrate prevention and encourage long-term adherence to the treatment plan. The appropriate PR program will train and motivate the patient to his or her maximum potential in self-care, and improve his or her overall quality of life.

b. Provisions of Section 144 of the MIPPA

In pertinent part, section 144 of the MIPPA amended section 1861(s)(2) of the Act to add a new subparagraph (CC) establishing coverage of items and services furnished under a ''pulmonary rehabilitation program.'' Pulmonary rehabilitation program is defined in new subsection (fff)(1) to mean a physician supervised program that furnishes several specific items and services. These include all of the following:

- Physician-prescribed exercise.
- Education or training (to the extent that the education and training is closely and clearly related to the individual's care and treatment and is tailored to such individual's needs).
- Psychosocial assessment.
- Outcomes assessment.
- Other items and services determined by the Secretary to be appropriate under certain conditions.

These components are to be provided in physicians' offices, hospital outpatient settings, and other settings determined appropriate by the Secretary. A physician must be immediately available and accessible for medical consultation and medical emergencies at all times when PR items and services are being furnished under the program. The individual's treatment is furnished under a written treatment plan that is developed by the physician for each beneficiary participating in a PR program. A physician must establish and review the plan and it must be signed by the physician every 30 days. This plan must include the individual's diagnosis, the scope of services to be provided in terms of type, amount, frequency and duration, and the goals set for the individual. To be covered and paid by Medicare, the PR program must provide all of the specified mandatory items and services. With respect to the Secretary's authority to require additional items and services, we are not proposing any additional services at the present time; however, we may propose additional items and services in the future.

c. Proposals

Under section 144 of the MIPPA, we are proposing to create a new § 410.47, ''Pulmonary Rehabilitation Program: Conditions for Coverage'' under Part B to add the PR program as a Medicare-covered service. The new section 1861(fff) of the Act outlines the mandatory components of a PR program. In accordance with this new section, any facility providing a PR program must meet all of the requirements outlined herein. The MIPPA provides for coverage of PR services in two specific settings (physician's office, hospital outpatient) and authorized the agency to consider the addition of other settings. We are not proposing any other settings at the present time.

The PR provisions defined by section 144 of the MIPPA are effective January 1, 2010.

(1) Definitions

We are proposing the following definitions for the programs and services required by MIPPA as related to PR provisions.

- *Individualized treatment plan:* A written plan which describes the individual's diagnosis; the type, amount, frequency and duration of the items and services to be furnished under the plan, including specifics related to the individual's particular needs for education and training; and the goals set for the individual under the plan.
- *Outcomes assessment:* A physician's evaluation of the patient's progress as it relates to his or her rehabilitation. The outcomes assessment is in writing and includes the following: (1) Pre- and post-assessments, based on patient-centered outcomes which are conducted by the physician at the beginning of the program and at the end of the program; and (2) objective clinical measures of exercise performance and self-reported measures of shortness of breath and behavior.
- *Physician:* A doctor of medicine or osteopathy as defined in section 1861(r)(1) of the Act.
- *Physician-prescribed exercise:* Physical activity, including aerobic exercise, prescribed and supervised by a physician that improves or maintains an individual's pulmonary functional level.
- *Psychosocial assessment:* A written evaluation of an individual's mental and emotional functioning as it relates to the individual's rehabilitation or respiratory condition.

This includes: (1) An assessment of those aspects of an individual's family and home situation that affect the individual's rehabilitation treatment; and (2) a psychosocial evaluation of the individual's response to and rate of progress under the treatment plan.

- *Pulmonary rehabilitation:* A short term physician-supervised program for COPD and certain other chronic respiratory diseases designed to optimize physical and social performance and autonomy.

(2) Coverage

We are proposing that Medicare Part B would cover PR for beneficiaries with moderate to severe COPD when ordered by the physician treating chronic respiratory diseases. A comprehensive PR program may be adapted for any person with chronic respiratory disease. The medical literature describes conditions associated with the possible need for PR including COPD, obesity-related respiratory disease, lung cancer, and neuromuscular diseases. However, the benefits of a PR program most strongly support its use for patients with moderate to severe COPD.

(a) Definition of Moderate to Severe COPD

Moderate to severe COPD is defined as GOLD classification II and III. The GOLD classification utilizes indices that measure airflow limitation and lung hyperinflation to determine severity of COPD. Specifically, the measurement of Forced Expiratory Volume (FEV) in the first second divided by the Forced Expiratory Vital Capacity (liters) (FEV1/FVC) gives a clinically useful index of airflow limitation. In other words, the volume of air exhaled that can be forced out in one second after taking a deep breath divided by the maximum volume of air exhaled as rapidly, forcefully and completely as possible from the point of maximum inhalation equals a numerical value used to grade COPD severity. Moderate and severe COPD are defined as:

- GOLD classification II (Moderate COPD)) is defined as FEV1/FVC<70 percent and FEV1 ≥30 percent to <80 percent predicted with or without chronic symptoms (Cough, sputum production, dyspnea).
- GOLD classification III (Severe COPD) is defined as FEV1/FVC < 70

percent and FEV1 < 30 percent predicted or FEV1 < 50 percent predicted plus respiratory failure or clinical signs of right heart failure.

Section 144 of the MIPPA does not specify the medical conditions for which coverage and payment are authorized for a PR program, other than a reference in the title to ''chronic obstructive pulmonary disease and other conditions''. Although the spectrum of possible conditions for which PR may be covered is broad, the medical guidelines most strongly supported the benefits of a PR program for individuals with moderate to severe COPD. The major national and international respiratory organizations (that is, ATS/ERS, the American College of Chest Physicians (AACP) jointly with the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR), and Global Initiative for Chronic Obstructive Lung Disease) have recommended PR as the standard of care in the treatment of moderate to severe chronic obstructive pulmonary disease represented by GOLD classification II or III. Because there is not data to substantiate significantly improved outcomes for any other medical conditions, we are proposing to allow moderate to severe COPD as the only covered condition. We propose to consider expanding coverage to patients with other medical conditions, should evidence support these additional uses. We would propose in our regulations to use the national coverage determination process to consider expanding coverage of PR for other chronic respiratory.

(b) Use of the NCD Process

We are proposing to use the national coverage determination process as authorized by section 1871(1) of the Act, to consider expanding coverage to items and services furnished by PR programs. The NCD process is open and transparent and provides an opportunity for public comments. Moreover, the NCD process affords CMS the ability to conduct a timely assessment of recent clinical evidence through a flexible and transparent process. It allows us to make uniform nationwide coverage determinations for items and services in a more flexible manner than rulemaking. In most circumstances, the NCD process is required to be completed within 9 to 12 months of the time that we accept a formal request for an NCD on a particular service. The NCD process will maximize the clinical benefit of PR for beneficiaries, and permit more rapid changes in response to emerging clinical evidence.

(3) Physician-Prescribed Exercise

Since the determination of the optimal time spent on each of the specific components within a PR program is highly individualized under the written plan of care, we are proposing to give the program medical director considerable flexibility. However, aerobic exercise is widely considered the cornerstone of pulmonary rehabilitation, and practice guidelines in the medical literature suggest exercise training of the muscles of ambulation as an essential component of a PR program. Each session must include some physician-prescribed aerobic exercise. We recommend both low- and high-intensity exercise to produce clinical benefits. It is suggested that exercise sessions involving a combination of endurance and strength training (to increase muscle strength and muscle mass) be conducted at least twice per week to achieve physiological benefits. Exercise may include use of treadmills, bicycles or other equipment, and should provide increased pulmonary function, strength, endurance, and flexibility.

(4) Education or Training Under the PR Program

Section 144 requires that education or training must meet the statutory requirements that mandate that it must be closely and clearly related to the individual's care and treatment, as well as meeting the specific needs of the individual. As part of the written individualized treatment plan the physician should evaluate and include only that education and training which addresses the needs particular to the patient that will further their independence in activities of daily living. The training and education prescribed should assist patients in learning to adapt to their limitations and improve the quality of their lives. Patients with COPD often use respiratory therapy modalities and equipment to aid their breathing. Education and training should be provided as necessary to ensure proper use and compliance with the physician's prescription. Instruction should include proper use, care, and cleaning of home respiratory equipment. Examples of equipment for which instruction would be appropriate include nebulizers/compressors, transtracheal oxygen (TTO), peak flow meters, and oxygen-conserving devices. Current medical literature provides for education as an integral component of pulmonary rehabilitation. The supervising physician must ensure the education or training helps further the primary objective of understanding and self-management of the chronic respiratory disease, specifically focused on COPD, including educational information on prevention and treatment of exacerbations. Examples of training sessions include those on respiratory techniques for physical energy conservation, work simplification, and relaxation techniques. Skills training and education also encourage behavioral changes by the patient, which can lead to improved health and long-term adherence. For example, brief smoking cessation counseling, as appropriate and respiratory problem management, should be included. Other topics for education may include the proper use of medications and nutrition counseling.

(5) Psychosocial Assessment

Section 144 of the MIPPA requires a psychosocial assessment as part of the PR program; we propose that it should be a written assessment. The initial assessment by program staff will evaluate aspects of the individual's family and home situation that may affect his or her treatment, and consider at the outset if referrals to support groups, community and/or home care services are necessary. Individual psychological considerations will also be addressed. For example, smoking is well known to be a cause of COPD. Depression and anxiety are commonly reported concerns for this patient population. Psychosocial intervention could help facilitate behavioral changes, such as smoking cessation, as well as assist with managing symptoms such as dyspnea. The assessment should include a written evaluation of the patient's need, as appropriate, for depression management, stress reduction, relaxation techniques, and strategies for coping with lung disease. This proposed rule does not propose any changes to the existing NCD (210.4) for ''Smoking and Tobacco-Use Cessation Counseling.''

The psychosocial assessment should include thorough screening and evaluation of the individual's lifestyle and other behaviors. Prior to each 30-day review of the individualized treatment plan, the program staff will conduct an evaluation of the individual's response to, and rate of progress under, the treatment plan and make recommendations to the physician as necessary. While the individualized treatment plan discussed below will assure that patients begin PR with a program tailored to their needs, periodic re-evaluations are necessary to ensure that their psychosocial needs are in fact being met.

(6) Outcomes Assessment

Section 144 of the MIPPA also requires that the PR program include outcomes assessment. In this proposed rule, we define outcomes assessment as an objective clinical measure of the effectiveness of the PR program for the individual patient. Patient-centered outcomes should be measured at the beginning of the PR program, prior to each 30-day review of the individualized treatment plan, and no later than at the end of the PR program. All such assessments are considered part of the PR program and as such are conducted in the appropriate settings and may not be billed separately. These measures should include clinical measures such as a 6-minute walk, weight, exercise performance, self-reported dyspnea (exertional and with daily activities), behavioral measures (supplemental oxygen use, smoking status), and a quality-of-life assessment. Some of the common program outcome measures examined in PR are functional exercise capacity, survival, and ADLs.

(7) Individualized Treatment Plan

Section 144 of the MIPPA requires that the physician develop, sign, and review an individualized treatment plan. In recognizing that PR programs are inherently highly individualized, we are proposing that the physician shall define and set the parameters, including types, amount, frequency and duration of the services, and goals, for the individual's treatment plan that include each of the four component services within the maximum duration of the program. The MIPPA requires the physician to establish the written individualized treatment plan at the start of the program and conduct subsequent reviews every 30 days. This plan may initially be developed by the referring physician or the PR physician. If the plan is developed by the referring physician who is not the PR physician, the PR physician must also review and sign the plan prior to initiation of PR. We would expect the supervising physician to have initial direct contact with the individual prior to subsequent treatment by auxiliary personnel. We would also expect at least one direct contact with the beneficiary in each 30-day period. Regardless, PR staff must provide both outcome and psychosocial assessments to the responsible physician prior to the 30-day deadline. Even if the PR staff makes recommendations for modifications to the program the physician will still be responsible for modifying the plan as needed, and reviewing and signing the plan prior to implementation for the individual. The MIPPA also requires written specificity relating to the type, amount, frequency and duration of items, and services furnished to the individual. Patients with chronic respiratory disease require individual attention, and assessments which address individualized needs must be designed to meet realistic individual goals. Therefore, the individualized plan of care should specify the mix of services necessary to address the patient's needs, as identified through the initial assessment, and based upon changes in the patient's condition. Further, it must include measurable and expected outcomes and estimated timetables to achieve these outcomes. The outcomes specified in the patient plan of care should be consistent with current evidence-based professionally-accepted clinical practice standards.

(8) Settings

In the MIPPA, the Congress has identified 2 appropriate settings for pulmonary rehabilitation, and also authorized the agency to provide additional settings for the PR program. We considered whether these new requirements should extend to CORFs, which are governed by different statutory provisions in section 1861(cc) of the Act. Given the differences in the statutory language, we do not propose extending the PR program requirements to CORFs. Individuals requiring PR program services have a chronic respiratory disease and are in need of supervised aerobic exercise, not physical therapy. Conversely, in the CORF setting physical therapy is the cornerstone component and a mandatory service, while exercise is not. Thus, the PR program is for an inherently different patient population, and allows for the first time, payment for exercise for COPD patients. Therefore, we propose not to include the CORF as a setting for a PR program. The respiratory therapy services performed in a CORF are part of a CORF program of services and not part of a PR program. We would consider the inclusion of additional settings through future rulemaking.

Both physician offices and outpatient settings must meet the standards as defined in the rule for safety and emergency care. These include both the immediate availability of the physician during the PR program and certain equipment requirements. In order to ensure proper safeguards in the statutorily-prescribed settings, the setting must have the cardio-pulmonary, emergency diagnostic and therapeutic equipment accepted as medically necessary by the medical community for emergency treatment related to a chronic respiratory disease condition. Some examples of this equipment are oxygen, defibrillators, and cardio-pulmonary resuscitation equipment. The setting must have all equipment and staff necessary to provide all of the statutorily-mandated items and services. We would expect that any additional settings which may be added through future rulemaking would similarly need to meet all of the aforementioned requirements.

(9) Physician Supervision

Section 144 of the MIPPA includes requirements for immediate and ongoing physician availability and accessibility for both medical consultations and medical emergencies at all times items and services are being furnished under the program. We are proposing to define such availability in accordance with existing definitions for direct physician supervision in physician offices and hospital outpatient departments at § 410.26(a)(2) (defined through cross reference to § 410.32(b)(3)(ii)) and § 410.27(f), respectively. Direct supervision, as defined in the regulations, is consistent with the language of the MIPPA because a physician must be present and immediately available where the services are being furnished. A physician must also be able to furnish assistance and direction throughout the performance of the services, which would include medical consultations and medical emergencies.

For PR services furnished in physicians' offices and other Part B settings paid under the PFS, this means that the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the service or procedure in accordance with § 410.26(b)(5). It does not mean that the physician must be in the room when the service or procedure is performed. For PR services provided to hospital outpatients, direct physician supervision is the standard set forth in the April 7, 2000 OPPS final rule with comment period (68 FR 18524 through 18526) for supervision of hospital outpatient therapeutic services covered and paid by Medicare in hospitals and provider-based departments of hospitals. We currently define and specify the requirement for direct supervision for services provided in provider-based departments of hospitals at § 410.27(f). For this purpose, the physician must be on the premises of the location (meaning the provider-based department) and immediately available to furnish assistance and

direction throughout the performance of the procedure. This does not mean that the physician must be present in the room when the procedure is performed. If we were to propose future changes to the physician office or hospital outpatient policies for direct physician supervision, we would provide our assessment of the implications of those proposals for the supervision of pulmonary rehabilitation services at that time.

The MIPAA provisions state that in the case of items and services furnished under such a program in a hospital, physician availability shall be presumed. As we have stated in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68702 through 68704), the longstanding presumption of direct physician supervision for hospital outpatient services means that direct physician supervision is the standard and we expect that hospitals are providing services in accordance with this standard.

(10) Physician Standards

The MIPPA authorizes the Secretary to establish standards to ensure that only a physician with expertise in the management of individuals with respiratory pathophysiology and who is licensed by the State where the PR program is offered shall be responsible for the program and direct the individual's progress. We propose to identify the physician who oversees or supervises the PR program in its entirety as the program medical director, and this may be the same physician providing, and billing for, the PR services. We are proposing that the program medical director must have training and proficiency in chronic respiratory disease management and exercise training of chronic respiratory disease patients. We further propose that the standards for program oversight shall include substantial involvement in the monitoring and direction of the patients' progress, and by implication, the staff that assists in furnishing the services. As part of his or her responsibility and accountability for the program, the program medical director will be expected to retain all records and documentation for each beneficiary which are ordinarily compiled in their clinical practice. We propose that the substantiation of the program medical director's expertise in respiratory pathophysiology would correlate to experience in the provision of care for individuals with chronic respiratory diseases. For purposes of referral for PR services, we are proposing to use the definition of ''physician'' specified in section 1861(r)(1) of the Act which defines ''physician'' as ''a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he or she performs such function or action (including a physician within the meaning of section 1101(a)(7) of the Act).'' We also propose that a supervising physician must be immediately available and accessible for emergencies and consultations.

(11) Sessions

Currently, PR is conducted with a widely varying number of sessions. We are unaware of any data that specifies an exact number of sessions that should be included in a PR program. However, published professional guidelines generally recommend ranges, typically 2 or 3 sessions per week over a period of 12 to 18 weeks for maximum physiological benefits. This equates to a range of approximately 24 to 54 sessions in total; the mean is 39 sessions. Since the primary goal of PR is to facilitate and encourage independent exercise at home, we believe coverage of 36 sessions in the facility setting is appropriate. Further, the current NCD (20.10) for cardiac rehabilitation allows for initial coverage of up to 36 sessions. Since the goals and objectives of these two programs are similar with respect to the patients' ability to achieve self-management of their diseases, we believe those limits are appropriate here. Therefore, we are proposing to allow up to 36 sessions for services provided in connection with a PR program. Patients should generally receive 2 to 3 sessions per week, which are a minimum of 60 minutes each. We propose to allow no more than one session per day, since these beneficiaries have significant respiratory compromise and would not typically be capable of doing more than one aerobic exercise session. We are especially interested in comments regarding the proposed optimal number of sessions, while acknowledging that each individual has a different degree of need.

(12) Other Items and Services

The MIPPA allows the inclusion of additional items and services as required elements of a PR program, under certain specific conditions. We are not proposing any additional items and services at the present time. We may consider the addition of other items and services through future rulemaking.

d. Coding

We are proposing to create one HCPCS code to describe and to bill for the services of a PR program as specified in section 144(a) of the MIPPA, GXX30, *Pulmonary rehabilitation, including aerobic exercise (includes monitoring), per session per day.* This G-code is to be billed when the patient performs physician-prescribed aerobic exercises that are targeted to improve the patient's physical functioning and may also include the other aspects of pulmonary rehabilitation, such as education and training. Because the physician's role in the PR program is defined in a similar manner to that in the cardiac rehabilitation program, we believe that the physician work component should be analogous to that of CPT code 93797, *cardiac rehab without telemetry.* Therefore we are proposing work RVUs of 0.18 RVUs for this new G-code. Using this same reference code, we are proposing that the malpractice RVUs be 0.01 RVUs.

To establish the PE RVU payment for the proposed new PR G-code, we reviewed the PE inputs of similar services, particularly those of the respiratory therapy HCPCS codes, G0237 and G0238, as well as the cardiac rehabilitation codes, CPT codes 93797 and 93798. Given the various individuals, acting under the supervision of a physician, can make up the PR multidisciplinary team, we believe that the clinical labor for the PR G-code can be best represented by the following labor types taken from the PE database: The nurse ''blend'' (RN/LPN/MTA), the respiratory therapist (RT), the social worker/psychologist and the medical/technical assistant—which we selected to represent various specialists involved in furnishing this service; these are valued at $0.37, $0.42, $0.45, and $0.26 per minute, respectively. Using an average of these values, $0.375 per minute, we are proposing to use the nurse blend labor type found in the cardiac rehabilitation CPT codes, at $0.37 per minute, as the typical value for the PR clinical labor and assigning 28 minutes of clinical labor time for the new PR G-code based on the various components of the proposed PR program.

For the equipment PE inputs, we reviewed the direct PE inputs for similar existing codes and are proposing a pulse oximeter (with printer), a 1-channel ECG, and a treadmill. Since no typical supplies were listed for similar existing codes in the PE database, we have not proposed any specific supplies for this proposed new G-code.

10. Section 152(b): Coverage of Kidney Disease Patient Education Services

Section 152(b) of the MIPPA provides for coverage of kidney disease education (KDE) services for patients. The

following is an outline of our proposals to implement the statutory amendments.

a. Background

The kidneys have several life-sustaining functions. Waste and excess fluid is removed by the kidney through filtration and the concentration of salt and minerals in the blood is maintained. Additionally, the kidneys help regulate blood pressure, are involved in the process of red blood cell production, and are needed for bone health. When kidneys are damaged, these functions are impaired.

Kidney damage can occur for a variety of reasons and may develop quickly (acute renal failure) or slowly. By definition, chronic kidney disease (CKD) is kidney damage for 3 months or longer, regardless of the cause of kidney damage. CKD typically evolves over a long period of time and patients may not have symptoms until significant, possibly irreversible, damage has been done. Complications can develop from kidneys that do not function properly, such as high blood pressure, anemia, and weak bones.

When CKD progresses, it may lead to kidney failure, which requires artificial means to perform kidney functions (that is, dialysis) or a kidney transplant to maintain life. There are tests to help detect kidney disease. Currently, the most important measurement of kidney function is called glomerular filtration rate (GFR) and is a measure of how quickly blood is filtered through the kidney's filter, which is called the glomeruli.

Patients can be classified into 5 stages based on their GFR, with Stage 1 having kidney damage with normal or increased GFR to stage 5 with kidney failure, also called end-stage renal disease (ESRD). Once patients with CKD are identified, treatment is available to help prevent complications of decreased kidney function, slow the progression of kidney disease, and reduce the risk of other diseases such as heart disease.

While predicting the timing of progression from stage IV CKD to kidney failure is difficult due to the lack of data, anticipatory objective information for the stage IV CKD patient is critical for management of comorbidities, prevention of uremic complications, and informed decision-making about renal replacement options and their respective benefits and risks. Collins notes from United States Renal Data System (USRDS) data from 2007 that ''despite the large number of patients with varying stages of CKD, only approximately 100,000 reach end-stage renal disease (ESRD) annually in the United States.'' [6] CKD primarily affects the elderly and commonly coexists with other chronic diseases including hypertension, diabetes, and cardiovascular disease. Consequently, the risk of mortality and morbidity are increased substantially with advancing CKD stages.

Individuals with CKD may benefit from educational interventions due to the large amount of medical information that could affect patient outcomes including the increasing emphasis on self-care and patients' desire for informed, autonomous decision-making. There is evidence that many pre-dialysis patients lack knowledge about their condition and may develop a sense of despair regarding their condition. Pre-dialysis education can help patients achieve better understanding of their illness, dialysis modality options, and may help delay the need for dialysis. Education interventions should be patient-centered, encourage collaboration, offer support to the patient, and be delivered consistently.

b. Statutory Authority

Section 152(b) of the MIPPA amended section 1861(s)(2) of the Act by adding a new subparagraph (EE) ''kidney disease education services'' as a Medicare-covered benefit under Part B. This new benefit is available for Medicare beneficiaries diagnosed with Stage IV CKD, who in accordance with accepted clinical guidelines identified by the Secretary, will require dialysis or a kidney transplant. KDE services will be designed to provide comprehensive information regarding:

- The management of comorbidities, including delaying the need for dialysis;
- Prevention of uremic complications;
- Options for renal replacement therapy (including hemodialysis and peritoneal dialysis, at home and in-center, as well as vascular access options and transplantation);
- Ensuring that the beneficiary has the opportunity to actively participate in his or her choice of therapy; and
- Tailored to meet the needs of the beneficiary involved.

c. Public Meetings

Section 1861(ggg)(3), as added by section 152(b) of the MIPPA, requires that the Secretary set standards for the content of the KDE services after consulting with various stakeholders, who to the extent possible, had not received industry funding from a drug or biological manufacturer or dialysis facility. On November 6, 2008, and December 16, 2008, we held two feedback sessions to solicit stakeholder comments regarding the implementation of section 152(b) of the MIPPA. Both feedback sessions were open to the public. In addition to the feedback sessions, we conducted an internal review of the available medical evidence, literature, and currently available CKD patient education programs. Transcripts from both events are available on the CMS Web site at *http://www.cms.hhs.gov/CoverageGenInfo/08_CKD.asp#TopOfPage*.

(1) The November 6, 2008 Feedback Session

The first feedback session was conducted as a Special Open Door Forum (ODF) at the CMS Headquarters on November 6, 2008. Approximately 200 people, representing approximately 70 organizations, participated via teleconference.

The majority of stakeholders cited the National Kidney Foundation Disease Outcomes Quality Initiative (NKF KDOQI) guidelines that define Stage IV CKD as a GFR measurement of 15–29 ml/min/1.73m^2, for purposes of classification and evaluation of CKD. Stakeholders recommended a variety of modalities for providing education services. One-on-one sessions between the educator and the patient were recommended to facilitate comprehension of the information. Stakeholders indicated that diagnoses of CKD can be devastating for some patients and patient outbursts, crying, and other disruptions can derail the educational process for large groups. Since all patients do not have the same learning styles or need for information, one stakeholder recommended that each individual be assessed by the treating physician or nonphysician practitioner (NPP) under the supervision of the treating physician for their learning needs and style preferences before or upon referral for KDE services.

Some stakeholders suggested that group education sessions would be appropriate and beneficial for patients, but did not comment specifically on the applicability to the Medicare population. Stakeholders reported that within existing programs, patients were going through a shared experience and group sessions helped facilitate discussion. Other stakeholders recommended that initial education sessions be performed in a group setting, with one-on-one follow-up sessions. We received recommendations

[6] Collins AJ, *et al.* ''Who Should be Targeted for CKD Screening? Impact of Diabetes, Hypertension, and Cardiovascular Disease.'' *American Journal of Kidney Diseases,* Vol 53, No 3, Suppl 3 (March), 2009: pg. S71.

regarding session length from 15 minutes to 2 hours, or as long as deemed necessary by the educator or the patient.

Some stakeholders recommended against using the Web or telemedicine since these modalities may not be appropriate or facilitate effective comprehension of material in older adults. Other stakeholders indicated that we needed to keep in mind that a patient's uremia may impair comprehension of the materials, that these patients are sick, and that the elderly often need to have information provided in a simplistic, repetitive manner.

Regarding the clinically appropriate topics and content standards for KDE services, various stakeholders indicated that the following information should be included in the curriculum:

- Basic overview of kidney functions and CKD pathophysiology.
- Survival rates based on choice of treatment or if the patient declines treatment.
- Quality of life and psychosocial adjustments.
- Structured, unbiased, uniform information about all renal replacement modalities, with no appropriateness assumptions presented by the educator.
- The right to decline treatment.
- Evidence-based content.
- Prolonging remaining kidney function.
- Patient participation in management of kidney disease.
- Sexuality and fertility issues.
- Transplant options.
- Smoking cessation.
- Medication compliance.
- Financial support and insurance coverage.
- Diet and exercise.
- Vocational rehabilitation.
- Treatment and management of comorbidities.

(2) The December 16, 2008 Feedback Session

On December 16, 2008, the second feedback session was hosted at the Agency for Healthcare Research and Quality (AHRQ). Approximately 60 people representing approximately 40 organizations participated. In preparing for this meeting, we researched and developed a list of approximately 30 experts and educators that are currently providing kidney disease education to individuals or treating patients with CKD, only 10 of which were able to participate. To accommodate those stakeholders that were unable to attend the AHRQ stakeholders meeting, we accepted additional feedback at the following e-mail address: *CKDEducation@cms.hhs.gov*.

We asked each meeting attendee to fill out a disclosure statement that described any industry funding he or she had received from a drug/biological manufacturer or dialysis facilities, since the MIPPA requested that we consult with various stakeholders, to the extent possible, that had not received such industry funding. The majority of the meeting participants or the organizations represented had received industry funding with few exceptions.

When asked about the accepted clinical criteria for classifying someone with Stage IV CKD, most stakeholders stated that Stage IV CKD is best defined as an individual with an estimated GFR of between 15 and 29 or 30 ml/min/1.73m^2. One stakeholder suggested that to decrease variability between creatinine methodologies, they recommended using a laboratory that traces its serum creatinine technique to IDMS (Isotope dilution mass spectrometry reference measurement procedure). This stakeholder also indicated that the MDRD (modification of diet in renal disease) study equation has been slightly modified to account for labs that are traceable to IDMS.

We asked the stakeholders to report on the different modalities of education that would be appropriate for kidney disease patient education. One stakeholder indicated that considerations need to be made regarding the educational needs of different communities and cultures. Several stakeholders indicated that face-to-face or group sessions are the preferred modalities for providing education services. One stakeholder indicated that groups larger than 20 may make it harder for all participants to ask questions. Stakeholders recommended that we allow flexibility to balance the needs of individual CKD patients that have varying degrees of need for information and education. Several stakeholders indicated that curriculum content should include information regarding all renal replacement therapy options (including no treatment), vascular access options, available support services, and management of co-morbidities including diabetes, blood pressure management, bone disease, and mineral metabolism.

Stakeholders recommended numerous frequency and duration combinations. One stakeholder recommended a variety of combinations of six 1-hour classroom group sessions including one session per week (over a 6-week period); six sessions over a weekend (3 sessions on Saturday; 3 sessions on Sunday); or all 6 sessions on 1 day during a weekend. This stakeholder also recommended that sessions should be standardized so that an individual can take sessions when they are offered to meet their scheduling needs. Stakeholders recommended sessions that lasted between 15 minutes and 2.5 hours. One stakeholder indicated that pre- and post-assessments should be included as part of the education programs.

When asked what factors in existing education programs have led to the best patient outcomes, we received a variety of responses such as varying the training format, providing information repetitively, and presenting information at the appropriate reading level for the audience. Stakeholders recommended that all aspects of the education services be provided in an objective and neutral manner, not skewing the information toward one or more renal replacement therapy modalities.

d. Implementation

Consistent with section 1861(ggg) of the Act, we are proposing to amend 42 CFR part 410 to add new § 410.48 for KDE services as a Medicare Part B benefit.

(1) Definitions (proposed § 410.48(a))

As related to the implementation of section 1861(ggg) of the Act, we are proposing the following definitions in § 410.48:

- Kidney Disease Patient Education Services: Consistent with section 1861(ggg)(1) of the Act, we are proposing to define Kidney Disease Patient Education Services as face-to-face educational services provided to patients with Stage IV CKD. We are proposing that the services be provided in a face-to-face manner based on stakeholder feedback received during the consultation meetings and our general rulemaking authority. Face-to-face education is consistent with sections 1861(ggg)(C)(ii) and (iii) of the Act, which provide that the services should be designed to ensure that the beneficiary has the opportunity to actively participate in the choice of therapy, and that the services be designed to be tailored to meet the needs of the beneficiary involved.

Some stakeholders recommended that sessions be conducted face-to-face due to varying patient literacy levels. Other stakeholders recommended against using Web-based education resources since the elderly may not be as comfortable with or lack access to the Internet. In light of these considerations, we believe that face-to-face education services are the most appropriate means for providing these services.

- *Physician:* For purposes of KDE services, a physician will be defined using the definition in section 1861(r)(1)

of the Act; it defines ''physician'' as ''a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he or she performs such function or action (including a physician within the meaning of section 1101(a)(7) [of the Act].''

• *Qualified Person:* Consistent with section 1861(ggg)(2)(A) of the Act, for purposes of KDE services, we are proposing to define a ''qualified person'' as a physician (as defined in section 1861(r)(1) of the Act); a physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1861(aa)(5) of the Act, and implemented in § 410.74, § 410.75, and § 410.76 of this subpart). A provider of services located in a rural area is also included in the statute's definition of a qualified person. Section 1861(u) of the Act defines ''provider of services'' to be ''a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program or, for purposes of sections 1814(g) and section 1835(e) [of the Act], a fund''. We are proposing to define a ''qualified person'' to include a provider of services located in a rural area and would include each of these healthcare entities except for a ''fund.''

We do not believe that it would be appropriate to recognize a fund described by sections 1814(g) and 1835(e) of the Act as a ''qualified person''. These funds are defined as providers of services only for the limited purpose of paying for the services of faculty physicians when they furnish certain services under the authority of sections 1814(g) and 1835(e) of the Act. These funds are not licensed as hospitals; they do not bill Medicare and do not receive payment. Moreover, these funds do not comply with Medicare conditions of participation and do not have provider agreements with Medicare. Because we do not believe that it would be appropriate to include ''funds'' in the definition of a ''qualified person'' for purposes of the KDE benefit, we are proposing to exclude funds described by sections 1814(g) and section 1835(e) of the Act from our definition of a provider of services located in a rural area as defined in section 1886(d)(2)(D) of the Act.

In order for a provider of services to be a ''qualified person,'' the entity must be located in a rural area. We are proposing to include in the definition of a ''qualified person'', only those hospitals, critical access hospitals (CAHs), skilled nursing facilities (SNFs), comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs), and hospice programs that are located in a rural area under section 1886(d)(2)(D) of the Act (as defined in our regulations at § 412.64(b)(ii)(C)) and to include hospitals and CAHs that are reclassified from urban to rural status pursuant to section 1886(d)(8)(E) of the Act, as defined in § 412.103. Specifically, § 412.64(b)(ii)(C) defines ''rural'' to mean any area outside an urban area, which § 412.64(b)(ii)(A) defines as a metropolitan statistical area (MSA) as defined by the President's Office of Management and Budget (OMB). Therefore, we believe that a hospital, CAH, SNF, CORF, HHA, or hospice program that is not physically located in an MSA should be considered ''rural'' for this benefit.

Section 1886(d)(8)(E) of the Act, implemented in § 412.103, requires us to treat hospitals that meet specified criteria as geographically rural under section 1886(d)(2)(D) of the Act even though they are physically located in an MSA. Because the statute identifies these hospitals as rural, we believe that it is appropriate to consider these hospitals a qualified person for purposes of the KDE benefit. The Conditions of Participation for CAHs in § 485.610 also include a provision to allow a hospital located in an urban area to reclassify as rural for purposes of becoming a CAH through section 1886(d)(8)(E) of the Act, as defined in § 412.103. Because a hospital or CAH specified under section 1886(d)(8)(E) of the Act is treated as being located in a rural area under section 1886(d)(2)(D) of the Act, we are proposing to recognize those hospitals or CAHs as a ''qualified person'' for purposes of the KDE benefit.

• *Renal Dialysis Facility:* The Congress has provided in section 1861(ggg)(2)(B) of the Act that a ''renal dialysis facility'' may not be a ''qualified person.'' We are defining this term, consistent with § 405.2102 of this title, as ''a unit which is approved to furnish dialysis service(s) directly to ESRD patients.''

• *Stage IV Chronic Kidney Disease:* Section 1861(ggg)(1)(A) of the Act states that KDE services shall be furnished to beneficiaries diagnosed with Stage IV CKD, who according to accepted clinical guidelines identified by the Secretary, will require dialysis or a kidney transplant. Based on stakeholder feedback, we are proposing to define Stage IV CKD as kidney damage with a severe decrease in GFR quantitatively defined by a GFR value of 15–29 ml/min/1.73 m^2, using the Modification of Diet in Renal Disease (MDRD) Study formula.[7] Because there are currently no agreed upon accepted clinical guidelines that describe the stage IV patients who would eventually require dialysis or a kidney transplant, we are proposing to cover all stage IV patients.

During both the November 6, 2008, and the December 16, 2008 feedback sessions, the majority of stakeholders indicated that Stage IV CKD is currently determined as kidney damage with a severe decrease in the estimated GFR value (15 to 29 mL/min/1.73 m^2). While there appeared to be agreement among the stakeholders regarding the estimated GFR values for the diagnosis of Stage IV CKD, some stakeholders indicated that only using the estimated GFR value to determine the severity of a beneficiary's CKD may be insufficient. To decrease variability between creatinine methodologies, stakeholders recommended using a laboratory that traces its serum creatinine technique to IDMS and that the MDRD study equation has been slightly modified to account for labs that are traceable to IDMS.

(2) Covered Beneficiaries (Proposed § 410.48(b))

Consistent with section 1861(ggg)(1)(A) of the Act, we are proposing that KDE services be furnished to beneficiaries with Stage IV CKD based on the definition of Stage IV CKD defined in proposed § 410.48(a), and have been referred for such services by the physician managing the beneficiary's kidney condition.

(3) Standards for Qualified Persons and Exclusions (Proposed § 410.48(c))

We are proposing to require that a qualified person be able to properly receive Medicare payment under 42 CFR part 424 (Conditions for Medicare Payment). In § 410.48(c), we are proposing to establish exclusions from the term ''qualified person.'' Consistent with section 1861(ggg)(2)(B) of the Act, we specifically exclude a hospital, CAH, SNF, CORF, HHA, or hospice that is physically located outside of a rural area under § 412.64(b)(ii)(C), except for a hospital or CAH that is treated as being located in a rural area under § 412.103. In addition, consistent with section 1861(ggg)(2)(B) of the Act, a renal dialysis facility is not a qualified person.

While we are not proposing specific education, experience, training, and/or certification requirements at this time,

[7] Levey, A.S., Greene, T., Kusek, J., and Beck, G.A. J Am Soc Nephrol. 2000. 11: p. 155A.; Levey, A.S., Bosch, J.P., Lewis, J.B., Greene, T., Rogers, N., and Roth, D. Ann Intern Med. 1999 Mar 16; 130(6):461–70.

we are specifically seeking public comments on the appropriate level of education, experience, training, and/or certification appropriate for a qualified person to effectively provide KDE services and may provide such provisions in the final issuance of this rule or in future rulemaking. Factors to consider include specific education and expertise regarding the topic and ability to explain these areas for the purpose of patient education:

- General kidney physiology and test results that would be associated with CKD.
- Psychological impact of the disease on the beneficiary, and impact on family, social life, work, and finances.
- The management of comorbidities (such as cardiovascular disease, diabetes, hypertension, anemia, bone disease, and impairments in functioning) common in persons diagnosed with CKD.
- Renal replacement therapeutic options, treatment modalities and settings, and advantages and disadvantages of each treatment option.
- Diet, fluid restrictions, and medication usage to include side effects and informed decisionmaking.
- Encouragement of patient active participation in decisionmaking and the ability to tailor educational needs to the individual beneficiary.
- Other areas of health deemed important to patients with CKD.

(4) Standards for Content of Kidney Disease Patient Education Services (Proposed § 410.48(d))

We believe that patient education needs vary by severity of the disease, the age of the patient, the patient's comorbid conditions and disabilities, the patient's primary language and culture, and desire to learn more about the disease and treatment options. Education services are more effective if the services are tailored to meet an individual beneficiary's needs. We are proposing that KDE services include the content as specified in proposed § 410.48(d). According to an article by Paula Ormandy [8] in the *Journal of Renal Care*, patients are most interested in receiving information on the following topics, which was echoed by many stakeholders during the feedback sessions.

- Basic information regarding CKD, how the kidneys work, what happens when the kidneys fail, and the permanence of the disease.
- Survival rates with and without renal replacement therapy and survival rates if the patient refused treatment for their CKD.
- The need for kidney transplantation.
- Unbiased information about renal replacement therapy (RRT) options including advantages and disadvantages for all modalities.
- Adequate information regarding why some RRT options were not viable for a patient.
- How different RRT options affected the patient's co-morbid conditions.
- Effect of RRT choices on lifestyle, such as treatment flexibility and treatment session length.
- Whether a patient will need assistance based on RRT modality choice and training requirements for helpers.
- The right to refuse treatment.
- Effects of the disease, and the subsequent treatment, on the patient's physical appearance.
- Patient recognition of the symptoms that would empower the patient with the knowledge to seek help.
- Disease and treatment complications related to renal replacement therapy such as hypertension, catheter migration, temporary/permanent loss of dialysis access, and risk of infection at the access sight.
- How to control and manage consequences of complications and symptoms (*for example:* treatment for itchy skin or insomnia).
- The ability to travel and organize holidays depending on RRT choice.
- Maintenance of social relationships, activities, and commitments.
- How the disease and RRT may affect the patient's ability to continue working.
- Available support services.
- Medication management, including side effects and risks related to non-compliance to prescribed medication regimen.

(5) Session Specifications (Proposed § 410.48(e))

(a) *Limitations on the number of sessions:* Consistent with section 1861(ggg)(4) of the Act, we will limit the number of KDE sessions to six (6).

(b) *Session Length:* In the absence of supporting evidence for session length, we are proposing to define the session length as 60 minutes which coincides with the session length of some programs in existence and is the approximate average of stakeholder suggested session lengths.

(c) *Individual and Group Session Format:* Consistent with section 1861(ggg)(C)(iii) of the Act, we are proposing that the qualified person tailor the design of the education services to meet the needs of the beneficiary based on whether the beneficiary needs more individualized education, would benefit more from a group environment, or a combination; and consider any communication accessibility needs based on disability, language and health literacy.

During the feedback sessions, we received a variety of recommendations regarding how education services should be provided, including a combination of group sessions, one-on-one sessions, and multi-media presentations. Stakeholders recommended that one-on-one sessions, between the beneficiary and the educator, facilitated quicker comprehension of the education materials than group sessions, and provided the best opportunity to tailor the sessions to meet the patient's needs. Other stakeholders indicated that group sessions provide patients with the benefit of responses to questions posed by different group participants.

Medical services, generally speaking, are provided to beneficiaries on an individual basis. Beneficiaries can also benefit from the interaction in a group setting. We believe that the beneficiary, in consultation with the referring physician, will be able to best determine the education services modality that most effectively meets his or her needs.

(6) Outcomes Assessment

The intent of the education services is for the beneficiary to take the information he or she has learned during the educational sessions in order to facilitate active participation by the beneficiary in the healthcare decisionmaking process with the physician managing his or her kidney condition. We believe that it is important that beneficiaries be assessed at the conclusion of the education sessions and are proposing that program assessments be used by the educators and CMS to assess the effectiveness of the education services, to help improve the programs for future participants, and better facilitate patient understanding of the material.

During the AHRQ stakeholders meeting, various stakeholders indicated that it was important to monitor the effectiveness of the education services to improve the content and delivery of KDE services. Assessing the effectiveness of the KDE services through assessments can be an effective way of measuring how beneficiary needs are being met. Some existing education programs have pre- and post-education session assessments and are usually administered immediately

[8] Ormandy, P., ''Information Topics Important to Chronic Kidney Disease Patients: A Systematic Review.'' *Journal of Renal Care* 34(1), 19–27, 2008.

following the conclusion of the education sessions.

We are proposing, based on stakeholder feedback and our general rulemaking authority, that qualified persons develop outcomes assessments and that each beneficiary be assessed during one of the education sessions. We are proposing that the outcomes assessment measure beneficiary knowledge about CKD and its treatment for the purpose, and as a contributor to, the beneficiary's ability to make informed decisions regarding their healthcare and treatment options.

According to an article by Gerald Devins in the *Journal of Clinical Epidemiology*, an outcomes assessment or test should be able to ''measure the adaptive value of ESRD-related knowledge as a contributor to psychosocial and physical well-being, * * * reliably and validly assess patient knowledge about ESRD and its treatment,'' * * * ''be easy to administer and score,'' and * * * ''require only basic reading skills.'' [9]

After completing the KDE services, the beneficiary should be able to take the information learned and use it to make informed choices about their healthcare during future consultations with the physician managing the beneficiary's kidney condition. It is important that the assessments be tailored to the beneficiary's reading level and language if the assessment is not administered by the qualified person that provided the education services, and be made available to CMS in a summarized format upon request.

We are specifically seeking public comments regarding the development and administration of the outcomes assessments. Factors to consider include:

- Specific topics that should be included as part of the assessment;
- Whether standardization of the outcomes assessment is feasible and/or should be considered;
- The applicability of any standardized assessments that may currently be in existence;
- The feasibility of providing both pre- and post-education assessments; and
- Methods for collecting assessments and disseminating best practices for KDE services.

e. Payment for KDE Services

Section 152(b) of the MIPPA creates a new benefit category for KDE services. The MIPPA amends section 1848(j)(3) of the Act, which allows for payment of KDE services under the PFS. KDE services are covered when they are furnished by a qualified person as defined in proposed § 410.48(a) and that meets the requirements of proposed § 410.48(c). We note that there is a possibility that a beneficiary may receive services from more than one ''qualified person''; however, payment should be made to only one qualified person on the same day for the same beneficiary.

The ''incident to'' requirements for physician services at section 1861(s)(2)(A) of the Act do not apply to KDE services because the MIPPA requirements are explicit, in that the education services must be provided by a qualified person, which is defined as a physician, nurse practitioner, clinical nurse specialist or physician assistant, and also includes a provider of services located in a rural area. In the past, we have taken the position that the ''incident to'' provision does not apply to the implementation of a new service with a distinct benefit category under the PFS. Therefore, the ''incident to'' requirements will not apply to KDE services.

Rural health clinics (RHCs) do not meet the statutory definition of a provider of services (as defined in 1861(u) of the Act) and cannot be separately paid for furnishing KDE services.

Section 1861(ggg)(4) of the Act limits the number of KDE services that a beneficiary may receive to six sessions. We are proposing to create two HCPCS codes, GXX26 (individual) and GXX27 (group), to describe and to bill for KDE services. The two G-codes consist of 1-hour face-to-face KDE services for an individual or group. We are proposing to pay both GXX26 and GXX27 at the nonfacility rate. We are also proposing that GXX26 educational services related to the care of chronic kidney disease; individual per session will be crosswalked to CPT code 97802; and that GXX27, educational services related to the care of chronic kidney disease; group, per session will be crosswalked to CPT code 97804. The rationale for the proposed pricing of the G-codes is based on the similarity of this service to medical nutrition therapy in the individual (97802) and group (97804) setting.

In the CY 2010 OPPS/ASC proposed rule, we discuss our proposed payment for KDE to qualified persons who are hospitals, CAHs, SNFs, CORFs, HHAs, or hospices. Commenters should submit specific comments on our payment proposal for this benefit, including the method and amount of payment, for qualified hospitals, CAHs, SNFs, CORFs, HHAs, or hospices in response to the CY 2010 OPPS/ASC proposed rule. We will discuss our final payment policy for these qualified providers in the CY 2010 OPPS/ASC Final Rule.

f. Effective Date

Medicare Part B coverage of outpatient kidney disease patient education services will be effective for services furnished on or after January 1, 2010.

11. Section 153: Renal Dialysis Provisions

Section 153 of the MIPPA requires changes to ESRD facilities for ESRD services effective January 1, 2010. The following is a summary of these changes.

Section 153(a)(1) of the MIPPA increases the current ESRD composite rate by 1.0 percent for services furnished on or after January 1, 2010. This also requires us to update the adjusted drug add-on. Since we compute the drug add-on adjustment as a percentage of the composite rate, the drug add-on percentage is decreased to account for the higher CY 2010 composite payment rate and results in a 15.0 percent drug add-on adjustment for CY 2010. As a result, the drug add-on amount of $20.33 per treatment remains the same for CY 2010, which results in a 15.0 percent increase to the base composite payment rate of $135.15. (*See* section II.I.6. of this proposed rule for further discussion.)

The composite rate paid to hospital-based facilities will be the same as the composite rate paid to independent renal dialysis facilities for services furnished on or after January 1, 2010. In addition, section 153(a)(2) of the MIPPA requires that in applying the geographic index to hospital-based facilities, the labor share shall be based on the labor share otherwise applied for renal dialysis facilities.

These MIPPA provisions are self-implementing and require no substantive exercise of discretion on the part of the Secretary. A detailed discussion of the MIPPA provisions can be found in section III. of the CY 2009 PFS final rule with comment period (73 FR 69881).

[9] Devins, G., *et al.* ''The Kidney Disease Questionnaire: A Test for Measuring Patient Knowledge about End-Stage Renal Disease.'' *J Clin Epidemiol.* Vol. 43, No. 3. pp. 297–307, 1990.

12. Section 182(b): Revision of Definition of Medically-Accepted Indication for Drugs; Compendia for Determination of Medically-Accepted Indications for Off-Label Uses of Drugs and Biologicals in an Anti-cancer Chemotherapeutic Regimen

a. Background

(1) Process for Revising the List of Statutorily Named Compendia

Generally, compendia are ''pharmacopeia providing information on drugs, their effectiveness, safety, toxicity, and dosing—are frequently used to determine whether a medication has a role in the treatment of a particular disease; these roles include both therapeutic uses approved by the U.S. Food and Drug Administration (FDA) and off-label indications'' (Agency of Healthcare Research and Quality (AHRQ), *Potential Conflict of Interest in the Production of Drug Compendia White Paper*).[10] Compendia are published by various institutions and by traditional reference book publishing houses.

Section 1861(t)(2)(B)(ii)(I) of the Act lists the following compendia as authoritative sources for use in the determination of a ''medically-accepted indication'' of drugs and biologicals used off-label in an anticancer chemotherapeutic regimen: American Medical Association Drug Evaluations (AMA–DE); United States Pharmacopoeia-Drug Information (USP–DI) or its successor publication; and American Hospital Formulary Service-Drug Information (AHFS–DI). Due to changes in the pharmaceutical reference industry, AHFS–DI is the only statutorily-named compendium that is currently in publication.

In addition to these compendia, the statute provides an alternative method for identifying medically-accepted off-label uses of drugs and biologicals in an anti-cancer chemotherapeutic regimen. Section 1861(t)(2)(B)(ii)(II) of the Act provides that local contractors may use ''supportive clinical evidence in peer-reviewed medical literature'' to make such determinations. Thus these medically-accepted uses could be identified even if there were no compendia recognized for this purpose. We discussed this in our response to comments in the CY 2008 PFS final rule with comment period (72 FR 66305).

Section 1861(t)(2)(B) of the Act provides the Secretary the authority to revise the list of compendia in section 1861(t)(2)(B)(ii)(I) for determining medically-accepted indications for off-label use of drugs and biologicals in an anti-cancer chemotherapeutic regimen. Consequently, in § 414.930, we established an annual process to revise the list and establish a definition of ''compendium'' in the CY 2008 PFS final rule with comment period (72 FR 66222, 66303 through 66306, and 66404).

On March 30, 2006, the Medicare Evidence Development and Coverage Advisory Committee or MEDCAC (formerly the Medicare Coverage Advisory Committee (MCAC)) met in public session to advise CMS on the appropriate criteria for the recognition of compendia for the identification of medically-accepted indications of drugs and biologicals used in an anti-cancer therapy, and the degree to which the then listed and other available compendia displayed those criteria. The evidence the MEDCAC considered to derive its recommendations included a presentation of the technology assessment (TA) performed for AHRQ by staff of the Tufts-New England Medical Center (Tufts-NEMC) and Duke Evidence-based Practices Centers (EPCs), scheduled stakeholder presentations, as well as testimony from members of the public. As is customary, the MEDCAC panelists elicited additional information from the presenters and discussed the evidence in preparation for a formal vote. The MEDCAC recommended that the following criteria, referred to as ''desirable characteristics,'' should be used to recognize compendia for identification of medically-accepted indications of drugs and biologicals in anti-cancer therapy:

- Extensive breadth of listings.
- Quick processing from application for inclusion to listing.
- Detailed description of the evidence reviewed for every individual listing.
- Use of pre-specified published criteria for weighing evidence.
- Use of prescribed published process for making recommendations.
- Publicly transparent process for evaluating therapies.
- Explicit ''Not recommended'' listing when validated evidence is appropriate.
- Explicit listing and recommendations regarding therapies, including sequential use or combination in relation to other therapies.
- Explicit ''Equivocal'' listing when validated evidence is equivocal.
- Process for public identification and notification of potential conflicts of interests of the compendia's parent and sibling organizations, reviewers, and committee members, with an established procedure to manage recognized conflicts.

We incorporated the MEDCAC recommended desirable characteristics into the compendia review process. All information on this MEDCAC meeting can be found on the CMS Web site at *http://www.cms.hhs.gov/mcd/viewmcac.asp?where=index&mid=33*.

Although we did not rank these ten MEDCAC desirable characteristics, the MEDCAC desirable characteristics that addressed transparency and conflict of interest of compendia were considered to be of high priority (72 FR 66304 through 66305). In addition, we considered the need to enhance transparency in the compendia review process to preserve the integrity of the review process (72 FR 66222, 66303 through 66306, and 66404).

During the 2008 compendium review cycle, we considered requests regarding the following five compendia: The AMA–DE Compendium; National Comprehensive Cancer Network Drugs and Biologics (NCCN) Compendium; Thomson Micromedex DrugDex Compendium; Thomson Micromedex DrugPoints Compendium; and Clinical Pharmacology Compendium. Our decisions are posted on the CMS Web site at *http://www.cms.hhs.gov/CoverageGenInfo/02_compendia.asp#TopOfPage*. In summary, we issued the following decisions regarding those compendia requests:

- NCCN was added to the list of compendia.
- Thomson Micromedex DrugDex was added to the list of compendia.
- Clinical Pharmacology was added to the list of compendia.
- Thomson Micromedex DrugPoints was not added to the list of compendia.
- AMA–DE was removed from the list of compendia.

(2) MIPPA Requirement for Compendia

Section 182(b) of the MIPPA amended section 1861(t)(2)(B) of the Act (42 U.S.C. 1395x(t)(2)(B)) by adding the sentence, ''On and after January 1, 2010, no compendia may be included on the list of compendia under this subparagraph unless the compendia has a publicly transparent process for evaluating therapies and for identifying potential conflicts of interests.'' There is a growing body of literature, including that from the Institute of Medicine (IOM),[11] that discusses the conflict of interest between research funding and

[10] Agency for Healthcare Research and Quality. White Paper: Potential Conflict of Interest in the Production of Drug Compendia. (2009, April 27). Available online at *http://www.cms.hhs.gov/mcd/viewtechassess.asp?from2=viewtechassess.asp&where=index&tid=64*.

[11] Institute of Medicine. Conflict of Interest in Medical Research, Education, and Practice. Available online at *http://www.nap.edu/catalog.php?record_id=12598*.

research results. Some authors have stated that there is a conflict of interest if an entity has a financial, legal, or political interest that is counterproductive to the performance of their legal or ethical responsibilities.[12] Although this widely discussed correlation depicts a classic representation of a financial conflict of interest, we believe nonfinancial conflicts of interests also deserve attention. Nonfinancial conflicts of interests have the potential to interfere with honest reporting, transparency and fair review of applications submitted to compendia publishers.[13] Therefore, in light of such concerns, the existence of financial and nonfinancial conflicts of interests would threaten the impartiality of the recommendations made in the compendia. We believe that section 182(b) of the MIPPA, ''Revision of definition of medically-accepted indication for drugs * * * Conflict of Interest'' is designed, in part, to address this issue in the compendia review process.

(3) Proposed Revisions of Compendia Standards

We believe that the implementation of this statutory provision that compendia have a ''publicly transparent process for evaluating therapies and for identifying potential conflicts of interests'' is best accomplished by amending the current definition of a compendium at § 414.930(a) to include the MIPPA requirements and by defining the key components of publicly transparent processes for evaluating therapies and for identifying potential conflicts of interests. In order to implement the MIPPA requirements concerning a publicly transparent process for evaluating therapies, we propose that a compendium could meet this standard by publishing materials used in its evaluation process on its Web site. This mode of publication provides broad contemporaneous public access to relevant materials. We believe that public access to such materials will increase transparency of the process used by compendia publishers for evaluating therapies and facilitate independent review of recommendations by interested parties. In addition, as discussed in the CY 2008 PFS final rule with comment period (72 FR 66305 through 66306), such disclosure may assist beneficiaries and their physicians in choosing among treatment options.

As expressed in the February 14, 2008 letter from the U.S. Senate Committee on Finance to the CMS Acting Administrator Kerry Weems, ''conflicts of interest have been proven in peer-reviewed studies to have a significant impact on scientific outcomes and medical care.'' [14] Since compendia recommendations are generally dependent on evidence from peer-reviewed studies, we believe that conflicts of interests may arise from relationships between individuals who substantively participate, such as individuals who contribute more than a clerical role, in the development of compendia recommendations and the applicants (for example, the manufacturer or seller of the drug or biological being reviewed by the compendium) for the inclusion of drug or biological recommendations in compendia. These relationships may involve, for example, publishers of compendia and peer-reviewed journals, their editorial or advisory boards, drug manufacturers, physicians or providers that derive income from the prescribing or administration of drugs, researchers that have a personal or academic interest in the drug study, or others who may provide incentives to influence the prescribing behaviors of physicians.[15] As illustrated in the AHRQ *Potential Conflict of Interest in the Production of Drug Compendia* White Paper, these potential financial and nonfinancial conflicts exist at the various stages of the evaluation process. The White Paper also describes compendia publication users (for example, the public, physicians, other caregivers, and public/private insurers) and the objectives of each user when referencing the compendia. Therefore, these potential financial and nonfinancial conflicts may be problematic for users of the compendia to rely on the validity of the compendia recommendations.[16]

Section 182(b) of the MIPPA requires a publicly transparent process for: (1) Evaluating therapies, and (2) identifying potential conflicts of interests. In light of these provisions, we are proposing regulatory safeguards to require that the publicly transparent process for evaluating therapies and identifying potential conflicts of interests include disclosure of certain relevant information. All currently listed compendia will be required to comply with these provisions, as of January 1, 2010, to remain on the list of recognized compendia. We view compendia publishers as generally responsible for the integrity of their publications. Therefore, we urge currently listed compendia publishers to submit evidence demonstrating compliance with the MIPPA provisions that ''no compendia may be included on the list of compendia'' unless the compendium has a publicly transparent process for therapy evaluation and conflict of interest identification to CMS no later than December 31, 2009. In addition, any compendium that is the subject of a future request for inclusion on the list of recognized compendia will be required to comply with these provisions. We believe that the statute is clear that no compendium can be on the list if it does not fully meet the standard described in section 1861(t)(2)(B) of the Act, as revised by section 182(b) of the MIPPA.

b. Revisions to § 414.930, ''Compendia for Determination of Medically-Accepted Indications for Off-Label Uses of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen''

We are proposing the following amendments to § 414.930(a):

- To revise the definition of ''compendium'' by adding an additional requirement that a compendium have a publicly transparent process for evaluating therapies and for identifying potential conflicts of interests.
- To add the definition of ''publicly transparent process'' for evaluating therapies. We propose that assurance of a publicly transparent evaluation process is best achieved by establishing a process that provides for public disclosure of the evidence considered and the review of that evidence leading to the development of compendia recommendations.[17] By providing for this disclosure, we hope to ensure validity in the use of compendia for identifying medically-accepted uses of off-label treatments for purposed of section 1861(t)(2)(B) of the Act. Thus, we believe that in the interest of providing a publicly transparent process

[12] Resnik, D. (2007, April). Conflicts of Interest in Scientific Research Related to Regulation and Litigation. *The Journal of Philosophy, Science & Law.* 7:1–16.

[13] The PloS Medicine Editors. (2008, September). Making Sense of Non-Financial Competing Interests. *PloS Medicine.* 5(9):1299–1301, Retrieved March 19, 2009 from *http://www.plosmedicine.org.*

[14] United States Senate Committee on Finance Correspondence. (2008, February 14). CMS Process and Actions Concerning Approval of Anti-Cancer Drug Compendia.

[15] The PloS Medicine Editors. (2008, September). Making Sense of Non-Financial Competing Interests. *PloS Medicine.* 5(9):1299–1301, Retrieved March 19, 2009 from *http://www.plosmedicine.org.*

[16] Agency for Healthcare Research and Quality. White Paper: Potential Conflict of Interest in the Production of Drug Compendia. (2009, April 27). Available online at *http://www.cms.hhs.gov/mcd/viewtechassess.asp?from2=viewtechassess.asp&where=index&tid=64&.*

[17] Resnik, D. (2007, April). Conflicts of Interest in Scientific Research Related to Regulation and Litigation. *The Journal of Philosophy*, Science & Law. 7:1–16.

for evaluating therapies and maximizing that transparency, a compendium should publish the complete application for inclusion, exclusion, or deletion of a therapy including criteria used to evaluate the request, on its Web site. We believe that in accordance with that publicly transparent process, a compendium should similarly publish the names of the individuals who have substantively participated in the development of compendia recommendations, along with transcripts of meetings and records of votes. This provides an opportunity for the public to consider the process used by the compendia in evaluating a specific therapy and independently reach conclusions about the adequacy of the application in light of the compendium's final recommendation. We request comments on the requirement for publication of a transcript and the suitability of other alternatives such as minutes or other documents.

• To add a definition regarding a ''publicly transparent process for identifying potential conflicts of interests,'' and clarify the essential elements of such a process. We propose that a publicly transparent process for identifying potential conflicts of interests is best demonstrated by a process that requires public transparency regarding the competing financial and nonfinancial interests that may give rise to such conflicts. Thus, we believe that a compendium should have a process for disclosing by publication on its publicly accessible Web site, certain information regarding potential conflicts of interests associated with individuals who are responsible for the compendium's recommendations as well as their immediate family members (as defined in § 411.351). A process for providing disclosure of interests by *immediate family members* is necessary because such interests could represent potentially competing financial conflicts that could influence the review and individuals responsible for the compendium's recommendations.[18]

We believe that the process for identifying potential conflicts of interests should include information regarding ownership and investment interests of those individuals who are responsible for the compendium's recommendation. Such information should include the names of those entities with which the individual has an ownership or investment relationship (similar to those relationships defined in § 411.354), the nature and length of the relationships, other financial relationships that may derive fron either a direct or indirect relationship (similar to thise relationships identified in 42 CFR 411.354, and the significance (for example, dollar value) of those relationships. By requiring a process for identification of such relationships, we are providing a process for the public to have access to information regarding potential conflicts of interests. We believe that information concerning the value of financial relationships is necessary because it would permit the public to assess the degree of influence that a relationship may have over an individual's decisions or judgments.[19] We request comments on the suitability of this process or whether the compendia should prescribe its own process. In addition, we request comments specifically addressing whether information regarding immediate family members is necessary for conflict of interest determinations.

We note that the publishers of the four compendia that are currently recognized for this purpose have already adopted conflict of interest disclosure policies that are similar to our proposal. Though there are individual differences among the publishers, we note that these policies commonly include publication on the compendia publisher's Web site of the name of the individuals that participate in the generation of the compendia recommendation and the entity with which there is a relationship, the nature of the relationship (for example, salary, ownership, grant support), and the value of the relationship. Some include this information as it relates to family members of the individual.

Additional information with respect to the conflict of interest policies of those compendia we reviewed during the 2008 review cycle can be found on their Web sites. For the convenience of the reader we have listed below the Web sites where these policies may be found for each of the four currently recognized compendia.

• *AHFS Drug Information: http://www.ahfsdruginformation.com/off_label/interest_disclosure.aspx.*

• *Thomson Micromedex DrugDex: http://www.micromedex.com/about_us/editorial/ed_ConflictofInterest.pdf.*

• Gold Standard Clinical Pharmacology: *http://www.goldstandard.com/editorial_conflict.html.*

• *The National Comprehensive Cancer Network: http://www.nccn.org/about/disclosure.asp?p=about.*

In general, certain disclosure policies of the compendia provide for public disclosure of individuals involved in the recommendation to ensure against the appearance of potential conflicts of interests. We believe that a publicly transparent process which provides for the identification of potential conflicts of interest protects the interests of the public, as well as those individuals who participate in the compendia process.

Disclosures of conflicts of interests are triggered by the recommendation regarding the use of the drug or biological rather than by the application for the recommendation. Disclosures published in conjunction with compendia recommendation updates should remain publicly viewable for a reasonable period of time. Specifically, we believe that the disclosures remain available for a period of not less than 5 years. It is not uncommon that serious questions about the use of a drug do not arise until the drug has been used for several years. Thus the relevance of information regarding the development of compendia recommendations may not be recognized until several years after the clinical use in question. We believe that a period of 5 years is a reasonable balance between the burden of maintaining this information and the public's interest in timely access to this information. We welcome comments regarding whether or not a period of not less than 5 years is an adequate timeframe for this balance to occur.

We recognize that some individuals may participate substantively in the development of more than one recommendation. For example, an individual might participate in the review of several drugs or biologicals for a single compendia publisher. We recognize that a single relationship may present a significant conflict of interest in some cases but not others. For example, a process for disclosure by the compendium publisher would be required if an individual whose only conflicted relationship arises from significant income related to the use of a particular drug for lung cancer substantively participated in the compendia review of that drug for lung cancer or for a competitor treatment for lung cancer. If that same individual substantively participated in the compendia review of a different drug for a different disease, the compendia publisher might determine that there is no conflict of interest to disclose.

[18] The PloS Medicine Editors. (2008, September). Making Sense of Non-Financial Competing Interests. *PloS Medicine.* 5(9):1299-1301, Retrieved March 19, 2009 from *http://www.plosmedicine.org.*

[19] Resnik, D. (2007, April). Conflicts of Interest in Scientific Research Related to Regulation and Litigation. *The Journal of Philosophy,* Science & Law. 7:1–16.

In § 414.930(b)(1), we are revising the CMS process for listing compendia for determining medically-accepted uses of drugs and biologicals in anti-cancer treatment to include consideration of a compendium's meeting of the regulatory definitions. We are also proposing to renumber the subparagraphs of § 414.930(b)(1) to accommodate this change.

Current § 414.930(b)(2) gives CMS the authority to generate an internal request to revise the list of compendia at any time.

H. Part B Drug Payment

1. Average Sales Price (ASP) Issues

a. Immunosuppressive Drugs Period of Eligibility

Section 9335(c) of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99–509) (OBRA '86) added subparagraph (J) to section 1861(s)(2) of the Act to define a benefit category for immunosuppressive drugs furnished to an individual who receives an organ transplant for which Medicare payment is made, for a period not to exceed 1 year after the transplant procedure. Coverage of these drugs under Medicare Part B began January 1, 1987.

Section 13565 of the Omnibus Budget Reconciliation Act of 1993 (Pub L. 103–66) (OBRA '93) amended section 1861(s)(2)(J) of the Act to specify that the benefit category included immunosuppressive drugs furnished: During 1995, within 18 months after the date of the transplant procedure; during 1996, within 24 months after the date of the transplant procedure; during 1997, within 30 months after the date of the transplant procedure; and during any year after 1997, within 36 months after the date of the transplant procedure. Beginning January 1, 2000, section 227 of the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (Pub. L. 106–113) (BBRA) extended the benefit period to eligible beneficiaries whose coverage for drugs used in immunosuppressive therapy expired during the calendar year.

Section 113 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (Pub. L. 106–554) (BIPA) revised section 1861(s)(2)(J) of the Act to eliminate the time limits for coverage of prescription drugs used in immunosuppressive therapy under the Medicare program. Effective with immunosuppressive drugs furnished to an individual who receives an organ transplant for which Medicare payment is made on or after December 21, 2000, there is no longer any time limit for Medicare benefits. Although the statutory benefit category no longer includes a time limit, our regulations at § 410.30(b) continue to reflect the time limits that applied previously. Therefore, we are proposing to make conforming changes to § 410.30(b) to remove the references to the time limits that applied under previous iterations of the statute. This technical change will reduce the potential for confusion about the scope of the benefit. We note that this proposal does not substantively affect Medicare coverage or benefits because it merely conforms the regulations text to the current benefit category, as specified in section 1861(s)(2)(J) of the Act. As noted above, under section 113 of the BIPA, immunosuppressive drugs have not been subject to a time limit since December 21, 2000.

b. WAMP/AMP Threshold

Section 1847A(d)(1) of the Act states that ''the Inspector General of HHS shall conduct studies, which may include surveys to determine the widely available market prices (WAMP) of drugs and biologicals to which this section applies, as the Inspector General, in consultation with the Secretary, determines to be appropriate.'' Section 1847A(d)(2) of the Act states that, ''Based upon such studies and other data for drugs and biologicals, the Inspector General shall compare the ASP under this section for drugs and biologicals with—

- The widely available market price (WAMP) for these drugs and biologicals (if any); and
- The average manufacturer price (AMP) (as determined under section 1927(k)(1) of the Act for such drugs and biologicals).''

Section 1847A(d)(3)(A) of the Act states that, ''The Secretary may disregard the ASP for a drug or biological that exceeds the WAMP or the AMP for such drug or biological by the applicable threshold percentage (as defined in subparagraph (B)).'' The applicable threshold is specified as 5 percent for CY 2005. For CY 2006 and subsequent years, section 1847A(d)(3)(B) of the Act establishes that the applicable threshold is ''the percentage applied under this subparagraph subject to such adjustment as the Secretary may specify for the WAMP or the AMP, or both.'' In CY 2006 through CY 2009, we specified an applicable threshold percentage of 5 percent for both the WAMP and AMP. We based this decision on the limited data available to support a change in the current threshold percentage.

For CY 2010, we propose to specify an applicable threshold percentage of 5 percent for the WAMP and the AMP. At present, the OIG is continuing its comparisons of both the WAMP and the AMP. In April 2008, we implemented a change in the weighting methodology for calculating ASP. Information on how recent changes to the calculation of the ASP may affect the comparison of ASP to WAMP or AMP is limited at this time. Since we do not have sufficient data that suggest another level is more appropriate, we believe that continuing the 5 percent applicable threshold percentage for both the WAMP and AMP is appropriate for CY 2010. Therefore, we are proposing to revise § 414.904(d)(3) to include the CY 2010 date.

As we noted in the CY 2009 PFS final rule with comment period (73 FR 69752), we understand that there are complicated operational issues associated with potential payment substitutions. We will continue to proceed cautiously in this area and provide stakeholders, including providers and manufacturers of drugs impacted by potential price substitutions with adequate notice of our intentions regarding such, including the opportunity to provide input with regard to the processes for substituting the WAMP or the AMP for the ASP. We welcome comments on our proposal to continue the applicable threshold at 5 percent for both the WAMP and AMP for CY 2010.

2. Competitive Acquisition Program (CAP) Issues

Section 303(d) of the MMA requires the implementation of a competitive acquisition program (CAP) for certain Medicare Part B drugs not paid on a cost or PPS basis. The provisions for acquiring and billing drugs under the CAP were described in the Competitive Acquisition of Outpatient Drugs and Biologicals Under Part B proposed rule (March 4, 2005, 70 FR 10746) and the interim final rule (July 6, 2005, 70 FR 39022), and certain provisions were finalized in the CY 2006 PFS final rule with comment period (70 FR 70236). The CY 2007 PFS final rule with comment period (72 FR 66260) then finalized portions of the July 6, 2005 IFC that had not already been finalized.

The CAP is an alternative to the ASP (buy and bill) methodology of obtaining certain Part B drugs used incident to physicians' services. Physicians who choose to participate in the CAP obtain drugs from vendors selected through a competitive bidding process and approved by CMS. Under the CAP, participating physicians agree to obtain all of the approximately 180 drugs on the CAP drug list from an approved CAP

vendor. The approved CAP vendor retains title to the drug until it is administered, bills Medicare for the drug, and bills the beneficiary for cost sharing amounts once the drug has been administered. The participating CAP physician bills Medicare only for administering the drug to the beneficiary. The initial implementation of the CAP operated with a single CAP drug category from July 1, 2006 to December 31, 2008.

After the CAP was implemented, section 108 of the MIEA-TRHCA made changes to the CAP payment methodology. Section 108(a)(2) of the MIEA-TRHCA requires the Secretary to establish (by program instruction or otherwise) a post payment review process (which may include the use of statistical sampling) to assure that payment is made for a drug or biological only if the drug or biological has been administered to a beneficiary. The Secretary is required to recoup, offset, or collect any overpayments. This statutory change took effect on April 1, 2007. Conforming changes were proposed in the CY 2008 PFS proposed rule (72 FR 38153) and finalized in the CY 2008 PFS final rule with comment period (72 FR 66260).

In the CY 2009 PFS proposed rule, we proposed several refinements to the CAP regarding the annual CAP payment amount update mechanism, the definition of a CAP physician, the restriction on physician transportation of CAP drugs, and the dispute resolution process (73 FR 38522). However, after the publication of the proposed rule, we announced the postponement of the CAP for 2009 due to contractual issues with the successful bidders. As a result, CAP physician election for participation in the CAP in 2009 was put on hold, and CAP drugs have not been available from an approved CAP vendor for dates of service after December 31, 2008. Physicians who participated in the CAP have transitioned back into the Average Sales Price (ASP) method of acquiring part B drugs for dates of service after December 31, 2008.

After the postponement was announced, we solicited public feedback on the CAP from participating physicians, potential vendors, and other interested parties. We solicited public comments on several issues, including, but not limited to the following: The categories of drugs provided under the CAP; the distribution of areas that are served by the CAP; and procedural changes that may increase the program's flexibility and appeal to potential vendors and participating physicians. We also hosted a CAP Open Door Forum (ODF) on December 3, 2008, where participants had an opportunity to discuss the postponement and suggest changes to the program. We appreciate the comments that we have received.

In the CY 2009 PFS final rule with comment period, we stated that we would review the public comments and consider implementing changes to the CAP before proceeding with another bid solicitation for approved CAP vendor contracts. Based on this information, in this proposed rule, we are addressing items that were not finalized in the CY 2009 PFS final rule with comment period, and making additional proposals for the CAP. Our approach seeks to better define certain aspects of the program based on our experience. We also seek to continue to increase participation by minimizing the administrative burden for physicians and vendors who choose to participate.

a. Frequency of Drug Payment Amount Updates

As described in the July 6, 2005 IFC (70 FR 39070 through 39071) and § 414.906(c), payment amounts for drugs furnished under the CAP are set through a competitive bidding process, and as described in § 414.908(b), bids that exceed a composite bid threshold of 106 percent of the weighted ASP for the drugs in the CAP category are not accepted. The CAP payment amounts that are calculated from successful bids are updated from the time of the bidding period to the payment year. During the 2006 through 2008 CAP contract period, the initial update calculation used the change in the Producer Price Index (PPI) for prescription preparations to account for the time period between the bidding and the period in which the payment amounts were to be in effect, which was the middle of the first year of the three year CAP contract period (70 FR 39074). Finally, as specified in § 414.906(c), CAP payment amounts are updated again during the second and third year of the contract period based on the approved CAP vendor's reported reasonable net acquisition costs (RNAC). The annual updates are limited by payment amounts described in section 1847A of the Act and codified in § 414.906(c).

Section 1847B(c)(7) of the Act gives the Secretary the discretion to establish an appropriate schedule for the approved CAP vendor's disclosure of RNAC information to us, provided that disclosure is not required more frequently than quarterly. In the July 6, 2005 IFC (70 FR 39075 through 39076), we specified that each approved CAP vendor will disclose its RNAC for the drugs covered under the contract annually during the period of its contract and that we would calculate an annual payment adjustment based on this information. We specified an annual disclosure of RNAC because it imposes the minimal burden on approved CAP vendors. In 2005, some commenters suggested that more frequent updates would be desirable. Additional feedback about the CAP that was obtained after the program's postponement in 2008, as well as comments on previous rules, indicated that potential vendors would like the frequency of price adjustments to increase. Various commenters have suggested a quarterly price adjustment in order to parallel to the ASP process, to better match payment amounts with increases or decreases in drug costs, and to attract vendor interest. We believe that quarterly adjustments would also lower approved CAP vendors' financial risks because CAP payment amounts will be better able to keep up with unanticipated drug cost increases and would benefit the Medicare program by reacting to significant cost decreases more promptly.

Quarterly price updates also will eliminate the PPI-based increase that currently occurs between the time bids are submitted and the first day of CAP claims processing. The application of the PPI-based payment adjustment described in the July 6, 2005 IFC (70 FR 39074) has resulted in situations where the ASP+6 percent payment amount has been exceeded during the first year of the 3-year approved CAP vendor contract. We do not believe that CAP payment amounts should exceed ASP+6 percent. In our discussion of bid ceilings in the July 6, 2005 IFC, we stated that the bid ceiling ''ensures that the CAP will be no more costly to the Medicare program than the alternative method of paying for drugs at 106 percent of ASP. This ceiling is thus consistent with the possibility of realizing savings to the Medicare program. It would also serve to maintain a level of parity between the two systems, preventing a situation in which significant payment differentials might skew incentives and choices (70 FR 39070).'' For this reason, and to remain consistent with current regulation text at § 414.906, we believe that all payment amounts calculated under the update process should be limited by the weighted payment amount established under section 1847A of the Act. We also believe that this approach will continue to provide for an ''appropriate price adjustment'' as required under section 1847B(c)(7) of the Act by improving responsiveness to unexpected price

changes, and continuing a prudent limitation on the magnitude of payment amount adjustments.

Our approach for implementing quarterly updates consistent with the ASP+6 percent limit on payment amounts would be based on composite bid price calculations, as described in the July 6, 2005 IFC (70 FR 39072 through 39073). Additional details about the process are described in further detail in section II.H.2.f. of this proposed rule (Annual CAP Payment Amount Update Mechanism). Briefly stated, the ASP+6 percent limit would be applied by comparing the (weighted) composite update payment amount, calculated from participating approved CAP vendors' reasonable net acquisition cost data, to most recent available weighted ASP prices for the same drugs. If the composite drug update payment amount exceeds the weighted ASP+6 percent payment limit, the composite payment amount for that group of drugs would be reduced to equal the ASP+6 percent limit by applying an equal percent reduction to each drug in the group. By way of example only, if a quarter's composite update payment was calculated as +2.3 percent, based on the median of all participating approved CAP vendors' data, but the calculated weighted ASP+6 percent limit for that group of drugs was +2.1 percent, the payment amounts for all HCPCS codes in the composite group would be increased by 2.1 percent in order to account for reported increases to the vendor's acquisition cost, but not to exceed the ASP+6 percent limit. This means that a 2.1 percent increase would be applied to CAP payment amounts for all HCPCS codes that are in the composite drug list and are being supplied under the CAP by one or more approved CAP vendors. For HCPCS codes that are priced separately, each code available through the CAP will be compared to the most recent ASP+6 percent limit for that code. CAP payment amounts for codes that exceed the ASP+6 percent limit will be reduced to ASP+6 percent. Each ''Not Otherwise Classified'' (NOC) drug described in § 414.906(f)(2)(iv), would also be updated on an individual (rather than composite) basis.

We are proposing to discontinue annual CAP payment amount updates and to implement quarterly CAP payment amount updates at § 414.906(c). Because of this proposed change, the special quarterly adjustments described at § 414.906(c)(2) (for the introduction of new drugs, expiration of drug patents or availability of generic drugs, material shortages, or withdrawal of a drug from the market) will no longer be needed, so we propose deleting those provisions from the regulation, and instead adding details about the payment amount update process described in section II.H.2.f. of this proposed rule (Annual CAP Payment Amount Update Mechanism). A quarterly RNAC reporting and payment adjustment process would begin as soon as we entered into contracts with the approved CAP vendor(s); that is, beginning with the first quarter during which CAP claims are submitted under the contract. Thus, under this proposal, we would also eliminate the PPI-based adjustment for the time period between the time bids are submitted and the time claims processing begins under the contract, because that adjustment would no longer be necessary. We believe using one payment update process will be easier to administer and would minimize the potential for CAP payment amounts to exceed ASP+6 percent for the first contract year. In order to provide sufficient time for the calculation of payment amount updates, we are proposing that approved CAP vendors report quarterly RNAC data for drug purchased for use under the CAP during the previous quarter within 30 days of the close of that quarter. We have made corresponding changes to regulation text at § 414.906(c) and we welcome comments on these proposed changes.

b. Changes to the CAP Drug List

(1) CAP Drug List

In the July 6, 2005 IFC, we responded to comments on our proposed approach for determining the CAP drug categories and how we select the specific drugs in the CAP drug list (70 FR 39026 through 39034). As stated in the CY 2006 PFS final rule with comment period (70 FR 70237), the CAP is intended to provide beneficiaries with access to Medicare Part B drugs and maintain physician flexibility when prescribing medications. Our approach incorporated drugs commonly administered by the range of physician specialties that bill for Part B drugs (70 FR 39030) and resulted in a list of about 180 drugs that were available through the CAP during the CY 2006 through CY 2008 contract period. We also developed a number of methods by which an approved CAP vendor's CAP drug list could be changed (*see* Table 26 at 70 FR 70242).

We believe that our general approach, to provide a wide variety of drugs to a variety of physicians over a large portion of the United States, is on target. Although we believe that the CAP is a means for physicians to minimize their drug inventory costs, we acknowledge that participation in the CAP cannot completely eliminate the need for participating CAP physicians to maintain at least a minimal drug inventory at the office. Many physicians who participate in Medicare also provide services to non-Medicare patients, and even physicians with a predominantly Medicare patient population may find it useful to keep a small stock of drugs on hand for unforeseen situations, such as emergencies and breakage.

During the CAP postponement, we became aware that both participating CAP physicians and potential vendors supported narrowing the CAP drug list. Both agreed that low cost drugs should be removed from the CAP. Although these items were initially included in the CAP so that an approved CAP vendor would be in a position to supply many of the Part B drugs that an office might administer, CAP physicians and the vendor community have stated that the inclusion of these items in the CAP creates an accounting, tracking, and claims submission burden for some participants. Based on these comments, we believe that low-cost, frequently utilized items, such as corticosteroid injections, could be removed from the list without significant impact on the CAP's utility to participating CAP physicians. Furthermore, it appears that physicians would be more interested in obtaining expensive products, such as biologicals, through the CAP. However, we are also mindful that narrowing the CAP drug list significantly also would decrease an approved CAP vendor's overall purchase volume, and we believe that this could limit the approved CAP vendor's ability to obtain volume-based discounts from the manufacturers or distributors from which it obtains drugs for use in the CAP. Creating a more tailored CAP drug category also could limit physician participation to one or several specialties, and may create a situation where sudden supply interruptions and unexpected changes to distribution channels could affect a greater proportion of drugs in the program than would be the case with a broader CAP drug category.

Nevertheless, we are proposing to create a new CAP drug category for the next round of CAP contracting. Our approach is intended to address comments about the administrative burden of tracking and billing low cost/high volume items while maintaining access to a variety of high cost items. We are proposing to identify the new CAP drug category using the existing CAP drug category as a starting point.

The 2008 drug list was compiled based on Part B drug claims data, the identification of specialties that frequently administer drugs under Part B, and public comment during rulemaking in 2005 (70 FR 39026 through 39033). We believe that using the 2008 CAP drug list as a starting point would maintain prescribing flexibility for a wide range of specialties and would also maintain access to a wide spectrum of drugs that have been utilized under the program previously. Furthermore, we do not believe it is necessary to develop a new approach because the 2008 CAP drug list was based on heavily utilized drugs in Medicare Part B physician practices; we believe that this approach is on target.

We propose to amend our list based on CAP physician participation, claims data, and comments indicating that the list should be narrowed to higher cost items. First, we would ''filter'' the original CAP drug category (drugs furnished in 2006 through 2009) by the specialties that most frequently prescribe drugs under the CAP, and the highest dollar volume CAP drugs (top 20 percent of allowed charges) compiled from 2008 claims data. This filtered list appears in Table 35, and we are proposing it as the starting point for the updated CAP drug category. A filtering process based on frequency of claims from a subset of physicians who might participate in the CAP cannot fully capture all drugs that may be used by certain specialties. In other words, the filtering steps described above narrow the CAP drug list based on physician specialties and dollar volume and do not necessarily preserve groups of drugs that certain prescribers may utilize, especially the less frequently utilized items in such groups. Therefore, we are also proposing to ''fill in'' groups of drugs with related items that do not appear on our list. We will consider ''filling in'' any drug or biological product that is physician-administered, has a reasonably high utilization in the Medicare population, is related to drugs already in the CAP (for example, because of similar clinical uses), and is otherwise appropriate for inclusion in the program.

For example, we could consider adding a fourth hyaluronan viscosupplement to the drugs in Table 35, expanding the list of antibiotics, or antiemetics, or by adding a list of ''new'' and unweighted drugs as in 2006 by using simple claims data thresholds (70 FR 70238). The concept of ''filling in'' drug groups is supported by feedback from former participating CAP physicians who suggested that certain categories of drugs, such as antibiotics, be more fully represented. We are seeking comments on specific drugs that should be added to the draft list in Table 35.

We also are seeking comment on the method to assess whether a particular drug should be ''filled in'' so that it is included in the new, narrowed CAP drug category. For example, one process that we have considered and would like comment on is adding drugs from the 2009 through 2011 CAP vendor bidding list that did not pass the ''filtering'' step described above. The 180 item 2009 through 2011 bidding list was used during the approved CAP vendor bidding for the 2009–2011 contract, and includes CMS-approved items added to the original contract's bid list, as well as items approved for addition during the 2006–2008 contract period. (*See* the Downloads section at *http://www.cms.hhs.gov/CompetitiveAcquisforBios/03a_vendorbackground.asp#TopOfPage*). This list's weighting is based on claims volume data by HCPCS code units rather than dollar volume and provides a different perspective than a dollar volume sorting. We would add drugs from the 2009–2011 CAP Vendor bid list to the CAP drug category if the drug's weight is in the top 25 percent of the 2009–2011 CAP vendor bidding list, indicating frequent claims submission, and if the drug's clinical uses are similar to a drug on the proposed list in Table 35. This method would result in the addition of a number of several commonly used antibiotics, two antiemetic) and several chemotherapeutic agents. Potential additions to our draft list identified by this method appear in Table 36. Although this method helps ''fill in'' the proposed CAP drug list, this method still does not fully capture less frequently used drugs, or newly approved drugs. We welcome comments on this method and alternative methods of filling this proposed list.

In order to provide additional flexibility for participating CAP physicians and approved CAP vendors, and to allow for participants to further tailor the program to meet their needs, we are also proposing to add § 414.906(f)(2)(v) to allow approved CAP vendors to submit a request to CMS to add drugs (or biologicals) to the list of drugs furnished by the requesting vendor if there is sufficient demand and if the drug has therapeutic uses that are similar to other drugs already available through the CAP. The request and approval process would follow the existing regulations at § 414.906(f), and HCPCS code additions that are requested under this process would still be subject to CMS approval. This proposed process adds to the process for adding newly issued HCPCS codes under § 414.906(f)(2)(iii) and newly approved drugs without HCPCS codes (NOC drugs)under § 414.906(f)(2)(iv). It is intended to facilitate more complete access to groups of drugs that may be used by certain specialties, and drugs used to treat certain disease states without having to rely on rigid definitions of classes of drugs that may not apply well to actual clinical practice across a large and diverse geographic area. We believe that this addition to the methods for changing an approved CAP vendor's drug list (*see* Table 26 in the November 21, 2006 final rule (70 FR 70242)) will add to the flexibility of the program. We welcome comments on our proposal to update the CAP drug list.

TABLE 35—DRAFT CAP DRUG LIST FOR NEXT CONTRACT PERIOD

Code	Procedure code description
J0129	INJECTION, ABATACEPT, 10 MG
J0215	INJECTION, ALEFACEPT, 0.5 MG
J0585	BOTULINUM TOXIN TYPE A, PER UNIT
J0587	BOTULINUM TOXIN TYPE B, PER 100 UNITS
J0696	INJECTION, CEFTRIAXONE SODIUM, PER 250 MG
J0878	DAPTOMYCIN INJECTION, 1 MG
J0881	INJECTION, DARBEPOETIN ALFA, 1 MCG (NON-ESRD USE)
J0885	INJECTION, EPOETIN ALPHA, (FOR NON ESRD USE), PER 1000 UNITS
J0894	INJECTION, DECITABINE, 1MG
J1440	INJECTION, FILGRASTIM (G-CSF), 300 MCG
J1441	INJECTION, FILGRASTIM (G-CSF), 480 MCG
J1740	INJECTION, IBANDRONATE SODIUM, 1 MG

TABLE 35—DRAFT CAP DRUG LIST FOR NEXT CONTRACT PERIOD—Continued

Code	Procedure code description
J1745	INJECTION INFLIXIMAB, 10 MG
J2323	INJECTION, NATALIZUMAB, 1 MG
J2353	INJECTION, OCTREOTIDE, DEPOT FORM FOR INTRAMUSCULAR INJECTION, 1 MG
J2357	OMALIZUMAB INJECTION, 5 MG
J2405	INJECTION, ONDANSETRON HYDROCHLORIDE, PER 1 MG
J2469	PALONOSETRON HCL, 25MCG
J2503	PEGAPTANIB, 0.3MG
J2505	INJECTION, PEGFILGRASTIM, 6 MG
J2778	INJECTION, RANIBIZUMAB, 0.1 MG
J2794	RISPERIDONE, LONG ACTING, 0.5MG
J3240	INJECTION, THYROTROPIN ALPHA, 0.9 MG, PROVIDED IN 1.1 MG VIAL
J3315	INJECTION, TRIPTORELIN PAMOATE, 3.75 MG
J3396	INJECTION, VERTEPORFIN, 0.1 MG
J3487	INJECTION, ZOLEDRONIC ACID, 1 MG
J3488	INJECTION, ZOLEDRONIC ACID (RECLAST), 1 MG
J7321	HYALURONAN OR DERIVATIVE, HYALGAN OR SUPARTZ, FOR INTRA-ARTICULAR INJECTION, Per Dose
J7322	HYALURONAN OR DERIVATIVE, SYNVISC, FOR INTRA-ARTICULAR INJECTION, PER DOSE
J7324	HYALURONAN OR DERIVATIVE, ORTHOVISC, FOR INTRA-ARTICULAR INJECTION, PER DOSE
J9010	ALEMTUZUMAB, 10 MG
J9035	BEVACIZUMAB INJECTION, 10MG
J9041	BORTEZOMIB INJECTION, 0.1MG
J9055	CETUXIMAB INJECTION, 10MG
J9170	DOCETAXEL, 20 MG
J9201	GEMCITABINE HCL, 200 MG
J9206	IRINOTECAN, 20 MG
J9263	INJECTION, OXALIPLATIN, 0.5 MG
J9305	PEMETREXED INJECTION, 10MG
J9310	RITUXIMAB, 100 MG
J9355	TRASTUZUMAB, 10 MG

TABLE 36—POTENTIAL ADDITIONS TO THE DRAFT CAP DRUG LIST FOR NEXT CONTRACT PERIOD (THAT IS, TABLE 35)

Code	Procedure code description
J3370	INJECTION, VANCOMYCIN HCL, 500 MG
J9264	PACLITAXEL PROTEIN BOUND PARTICLES, 1MG
J0690	INJECTION, CEFAZOLIN SODIUM, 500 MG
J1260	INJECTION, DOLASETRON MESYLATE, 10 MG
J0692	INJECTION, CEFEPIME HYDROCHLORIDE, 500 MG
J1626	INJECTION, GRANISETRON HYDROCHLORIDE, 100 MCG
J0640	INJECTION, LEUCOVORIN CALCIUM, PER 50 MG
J9265	PACLITAXEL, 30 MG
J9190	FLUOROURACIL, 500 MG
J9045	CARBOPLATIN, 50 MG
J0290	INJECTION, AMPICILLIN SODIUM, 500 MG
J9214	INTERFERON, ALFA–2B, RECOMBINANT, 1 MILLION UNITS

2. Removing Drugs From the CAP list

Although there are several methods under the CAP to add drugs to an approved CAP vendor's drug list, the current regulations do not specify a process for removing drugs from an approved CAP vendor's list. Our experience has shown that interruptions in availability can affect an approved CAP vendor's ability to supply CAP drugs during the course of a 3-year contract. For example, during the first contract period, we became aware of long-term and permanent drug unavailability, sometimes at the HCPCS level, due to removal of drugs from the market, or interruption of supply to an approved CAP vendor for reasons beyond the approved CAP vendor's control, such as changes to drug distribution methods, changes in agreements between manufacturers and distributors and/or pharmacies regarding who may purchase certain drugs, and direct distribution arrangements.

In order to better respond to sudden, long-term changes in drug supply that are beyond the control of the approved CAP vendor, we are proposing to allow an approved CAP vendor to request the permanent removal from its CAP drug list of a HCPCS code for which no NDCs are available. Our proposal is intended to better manage situations where all NDCs from an entire HCPCS code unexpectedly become unavailable to an approved CAP vendor, and we would require the approved CAP vendor (1) to document the situation in writing, including the unavailability of all NDC codes in a HCPCS code that is supplied under the CAP, (2) to describe the reason for the unavailability and its anticipated duration, and (3) to attest that the unavailability is beyond the approved CAP vendor's control. Approval of the deletion would apply only to the approved CAP vendor or vendors that requested the deletion. Our proposal is not intended to be used frequently, or to permit an approved CAP vendor to remove a HCPCS code from its CAP drug list simply because it has become unprofitable to provide it—we believe the payment amount adjustment proposals discussed in sections II.H.2.a. and f. of this proposed rule would address that concern.

Furthermore, our proposal is also not intended to be used for managing short-term unavailability, or unavailability of a finite duration—we believe the existing drug substitution policy described in § 414.906(f) already addresses those concerns. We are proposing to add this process as § 414.906(g) because those regulations currently provide for additions and substitutions to the CAP drug list, and would therefore require a written request to CMS, as well as CMS' approval.

Participating CAP physicians who are affected by the deletion of a HCPCS code from an approved CAP vendor's drug list would have the option of remaining with their selected approved CAP vendor and using the ASP (buy and bill) methodology for obtaining the drug that has been deleted, or selecting another approved CAP vendor under the exigent circumstances provision at § 414.908(a)(2). We believe that the deletion of an expensive and highly utilized CAP drug by one approved CAP vendor in the middle of a physician election period could cause hardship for a practice if it had to revert to the ASP methodology of acquiring and billing for that drug. Such a situation would constitute an exigent circumstance. Given CAP's goal of improving access to drugs, allowing the participating CAP physician to switch approved CAP vendors outside of a regular election period in this instance would be prudent. We welcome comments on our proposals.

c. Geographic Area Served by the CAP

In the July 6, 2005 IFC (70 FR 39034 through 39036), we established a single, national competitive acquisition area for the initial stage of the CAP. This national distribution area included the 50 States, the District of Columbia, Puerto Rico, and U.S. territories. We recognized that designating a single national area might limit participation to those vendors that could compete to bid and supply drugs nationally, but we indicated this approach was a part of the phase-in plan for the CAP. We also discussed potential phase-in options for the future, stating that smaller areas might become a solution as the program expanded.

According to the vendor community, certain areas of the United States (especially Alaska, Hawaii, and the Territories) currently present logistical challenges and are associated with high drug shipping costs. Moreover, physician participation in these areas has been low; in 2008, physicians from Alaska, Hawaii, and the Territories represented less than 2 percent of total participating CAP physicians. Temporarily limiting the geographic areas served by the CAP could help limit costs and risks for approved CAP vendors associated with shipping drugs to distant parts of the country. However, we believe that the CAP is intended to provide services to all Medicare physicians (including those in distant parts of the country), and therefore, we do not believe that a limitation on the geographic area in which the CAP is available should be permanent.

Section 1847B(a)(1)(B) of the Act specifically requires the Secretary to phase-in the CAP with respect to the categories of drugs and biologicals in the program, in such a manner as the Secretary determines to be appropriate. We believe that this provision, particularly in conjunction with the statutory definition of a competitive acquisition area as ''an appropriate geographic region established by the Secretary'' provides broad authority for the Secretary to phase in the CAP with respect to the geographical areas in which the program would be implemented. As stated in the July 6, 2005 IFC, we considered several factors when defining geographic areas for the CAP, including aspects of vendors and their distribution systems, such as current geographic service areas, the density of distribution centers, the distances drugs and biologicals are typically shipped, and costs associated with shipping and handling (70 FR 39035). Taking these factors into consideration again, and considering entities who have bid on, or expressed interest in bidding on approved CAP vendor contracts, we believe that it is appropriate to use the authority granted under the Statute to temporarily narrow the area served by the CAP during the program's re-implementation. We appreciate the logistical issues associated with shipping drugs to remote areas and the uncertainties associated with transportation costs that have been described by the potential vendor community; however, we are reluctant to significantly reduce the area served by the CAP because at some point, the approved CAP vendor's volume would be affected and the likelihood of obtaining volume based discounts would decrease.

At this time, we are proposing to designate the CAP competitive acquisition area as the 48 contiguous States and the District of Columbia for the next round of CAP contracting. This change in the geographic area that is served by the CAP is meant as an interim measure under our phase-in authority and the statutory definition of a competitive acquisition area. We believe that omitting Alaska, Hawaii, and the Territories from the CAP competitive acquisition area at this time will balance the need to revise the CAP to attract more vendors with the need to offer the maximum number of physicians a meaningful opportunity to participate. We believe that this proposal will encourage potential vendors to participate in the CAP because it would temporarily omit areas associated with low physician participation, long shipping times, and high shipping costs. Furthermore, this measure is unlikely to significantly decrease CAP drug order volume relative to historical physician participation in the CAP. However, we are aware that our proposal temporarily eliminates the CAP option for physicians in the areas not included in this CAP competitive acquisition area. Therefore, we are not proposing this definition of the CAP geographical area as a permanent solution. We will continue to assess the CAP and update plans for phase in activity in future rulemaking efforts, including determining the circumstances under which CAP participation will be offered to physicians in Alaska, Hawaii, and the Territories. We will also continue to consider modifying the definition of competitive acquisition area on the basis of regions, States, or some smaller geographic area, which might expand the number of vendors that could bid to participate in the program (70 FR 39036). We welcome comments on our proposal.

d. CAP Drug Stock at the Physician's Office

Our discussion about the CAP emergency restocking option in the July 6, 2005 IFC indicated that a participating CAP physician could not maintain a stock of an approved CAP vendor's drug in his or her inventory. This was done because we had reservations about potential program integrity and drug diversion issues (70 FR 39047).

Since that time, we have gained operational experience with the CAP and a better understanding of the ordering and drug delivery process. We have also received additional public feedback about the different ways that the program could be refined. Further, our experience with the CAP indicates that our concerns over program integrity and drug diversion have not come to pass. For example, we have received no complaints and have no information indicating that diversion has been a concern. Also, we have not received any negative feedback from the vendor community indicating a concern about

storing CAP drugs in physicians' offices. Therefore, we believe at this time it is appropriate to consider allowing additional flexibility to encourage CAP participation.

Our experience with the CAP, and our increased understanding about the options approved CAP vendors might have for furnishing drugs to a participating CAP physician's office also support considering additional flexibility in this area. For example, we are aware of electronic inventory control and charge capture devices that could be utilized in ways that conform to CAP regulations and are compliant with applicable State and Federal laws. Such devices utilize an electronic transaction based on a physician's order to track the administration of drugs from inventory to a specific patient and to document appropriate charges for the drug. We believe that such systems could fit into the current CAP framework when transactions in such systems are based on a physician's order, because such systems can track inventory, and can be used to capture patient charge data.

For these reasons, we are seeking to clarify our requirements for the manner in which CAP drugs are supplied to participating CAP physicians. Specifically, we are proposing to allow approved CAP vendors to utilize electronic transactions to furnish CAP drugs from nominal quantities of approved CAP vendor-owned stock located at the physician's office in response to specific prescription orders and to capture charges related to such transactions. Our proposal is also intended to clarify that entities with alternative approaches to supplying drugs that utilize an electronic transaction are welcome to participate in the CAP bidding process. We believe that this will allow for additional flexibility and efficiency in the ordering and delivery of drugs within the program because it allows for more efficient shipping of approved CAP vendor-owned stock and provides the option of CAP participation for physicians who use or may choose to use such drug inventory management platforms. This proposal does not change our position that a participating CAP physician shall not take title to or pay for CAP drugs, nor does it alter the requirements for information that must be submitted with a prescription order under Section 414.908(a) or the application of HIPAA to such data.

Furthermore, our proposal does not affect the applicability of State licensing requirements for an approved CAP vendor. As stated in the July 6, 2005 IFC (70 FR 39066), either the approved CAP vendor, its subcontractor under the CAP, or both, must be licensed appropriately by each State to conduct its operations under the CAP. Therefore, if a State requires it, an approved CAP vendor would be required to be licensed as a pharmacy, as well as a distributor. We are not revising the requirements at § 414.908(c) and § 414.914(f)(9), and we note that sections 1847B(b)(6) and 1847B(b)(2)(B) of the Act continue to apply. In order to participate in the CAP successful bidders must continue to submit proof of pharmacy licensure, consistent with applicable State requirements.

Also, this proposal would not modify our definition of ''emergency delivery'' or its corresponding requirements at § 414.902. As we stated in our July 6, 2005 IFC, the intent of the 1-business-day timeframe for emergency deliveries is to address the participating CAP physician's need for more rapid delivery of drugs in certain clinical situations with the approved CAP vendor's ability to ship the drug and have it delivered promptly in a nationwide delivery area (70 FR 39045). The emergency delivery timeframe still applies in situations when CAP drugs are not available in the office for electronic delivery.

Moreover, this proposal does not seek to change the CAP inventory requirements. CAP drugs belong to the approved CAP vendor, and as indicated in the July 6, 2005 IFC (70 FR 39048), participating CAP physicians are required to maintain a separate electronic or paper inventory for each CAP drug obtained. CAP drugs must be tracked separately in some way (for example, an electronic spreadsheet). CAP drugs do not have to be stored separately from a physician's own stock; that is, co-mingling of CAP drug with drug from a participating CAP physician's own private stock is acceptable as long as a record of approved CAP vendor-owned drug is kept in a manner that is consistent with § 414.908(a)(3)(x) and the approved CAP vendor-owned drug can be accounted for, as needed.

Also, this proposal does not affect the CAP emergency restocking requirements. Section 1847B(b)(5) of the Act and § 414.906(e) provide criteria for the replacement of drugs taken from a participating CAP physician's inventory in the event of an emergency situation. When the emergency resupply criteria are met, a participating CAP physician can replace the drugs that were used from his or her own inventory by submitting a prescription order to the approved CAP vendor.

Our proposal seeks to clarify the potential approaches that a bidder may use (separately or in combination) to supply drugs under the CAP. Our proposal does not seek to specify a particular approach that bidders must use in future responses to CAP bid solicitations or to strictly define the types of entities that could bid on CAP vendor contracts; for example, whether bidders must be pharmacies, drug distributors, or a hybrid of the two; whether bidders must utilize just in time shipping, or electronic inventory transactions to supply CAP drugs. We will consider approving bidders' approaches that are consistent with the statutory framework, applicable laws, and regulations. We welcome comments on this issue.

e. Exclusion of CAP Sales From ASP Calculations

In response to the March 4, 2005 proposed rule, many commenters requested clarification about whether the prices determined under the CAP will be taken into account in computing the ASP under section 1847A of the Act. In the July 6, 2005 IFC, we responded that prices offered under the CAP must be included in ASP calculations (70 FR 39077). This was done because we initially believed that we did not have the statutory authority to exclude prices determined under the CAP from the computation of ASP under section 1847A of the Act. Section 1847A(c)(2) of the Act contains a specific list of sales that are exempt from the ASP calculation, and sales to approved CAP vendors operating under CAP are not included on that list (70 FR 39077). Comments received in response to the July 6, 2005 IFC opposed this policy (70 FR 70479).

Ultimately, as stated in the November 21, 2005 IFC, we recognized commenters' concerns about the effect of including CAP prices in the calculation of ASP and agreed that the best outcome for both the ASP methodology and the CAP programs would be one in which prices under CAP did not affect payment amounts under the ASP methodology. In particular, we found compelling arguments from commenters about the separation of the ASP and CAP programs and that the two programs are intended to be alternatives to each other. Therefore, we excluded units of CAP drugs that are administered to beneficiaries by participating CAP physicians from the ASP calculation for the initial 3-year approved CAP vendor contract period (70 FR 70479). Accordingly, the definition of ''Unit'' at § 414.802 was also revised to reflect this exclusion.

In our August 18, 2006 interim final rule, we further addressed concerns

pertaining to our definition of Unit. We published a PRA notice regarding a proposed modification of the OMB-approved ASP information collection requirements (CMS Form 10110 (OMB # 0938–0921) about the collection of the number of CAP units excluded from the ASP calculation. In response, a commenter expressed concern over manufacturers' reliance on approved CAP vendors for information about the number of units of CAP drugs that are administered to beneficiaries by participating CAP physicians (71 FR 48132). Since approved CAP vendors are the only entities with direct information on CAP units administered, the commenter believed that the requirement to exclude units of CAP drugs administered to beneficiaries by participating CAP physicians placed the manufacturer in the untenable position of reporting ASP and certifying reports of ASP based on second-hand information from approved CAP vendors. Further, the commenter noted that manufacturers may not have timely access to this information and that they could not independently confirm its accuracy (71 FR 48132). Additional feedback received as part of our ongoing work with manufacturers also indicated that they were concerned that they would have difficulty obtaining information from approved CAP vendors that would be necessary to accurately exclude administered CAP units from the ASP calculation (71 FR 48132).

Therefore, we further revised the definition of unit to clarify that for the initial 3-year contract period under the CAP units of CAP drugs sold to an approved CAP vendor for use under the CAP would be excluded from the calculation of ASP (70 FR 48132).

In the July 6, 2005 and August 18, 2006 IFCs, we stated that we would examine the effect of this exclusion and, if necessary, revisit our decision at the end of the initial 3-year period of the CAP (70 FR 70480 and 71 FR 48132, respectively). Since then, operational experience has not indicated a reason for changing our policy of excluding CAP units sold to approved CAP vendors for use under the CAP from ASP calculations. Therefore, we are proposing to permanently exclude drugs supplied under the CAP from ASP calculations and make conforming changes to the definition of unit at § 414.802. We believe that this proposal will continue to promote the separation and independence of the two drug payment models. We welcome comments on this proposal.

f. Annual CAP Payment Amount Update Mechanism

In the July 6, 2005 IFC (70 FR 39076), we described a two-step process to calculate RNAC-based price adjustment if there is a change in the RNAC reported by a particular approved CAP vendor. We stated that ''we would adjust the bid price that the vendor originally submitted by the percentage change indicated in the cost information that the vendor disclosed. Next, we would recompute the single price for the drug as the median of all of these adjusted bid prices.'' The two-step process contemplated that there would be more than one approved CAP vendor at the time prices were to be adjusted and that all successful bidders would participate in the CAP.

However, during the first round of CAP contracting, after offering more than one contract, we entered into a contract with only one successful bidder. Thus, during the 2008 price update calculation process, we developed an approach to account for the lack of RNAC data for bidders who chose not to participate in the CAP. In the CY 2009 PFS proposed rule, we stated that the approach we used to adjust prices for the 2008 contract year is consistent with § 414.906(c) and with the July 6, 2005 IFC because it retains a two-step calculation based on the approved CAP vendor's RNAC, as well as the calculation of a median of adjusted bid prices.

We also posted our approach on the Approved CAP Vendor page of the CMS CAP Web site at *http://www.cms.hhs.gov/CompetitiveAcquisforBios/15_Approved_Vendor.asp*. The percent change in RNAC for 2008 was calculated based on data supplied by the approved CAP vendor. This percent change in RNAC was used as a proxy for the percent change in RNAC for successful bidders that chose not to become approved CAP vendors.

Then, in the CY 2009 PFS proposed rule (73 FR 38522 through 38523), we proposed to continue using this approach for future CAP payment amount updates where the number of approved CAP vendors is less than the number of successful bidders. We proposed that the average of the approved CAP vendor-supplied RNAC data would be used as a proxy for data from vendors who bid successfully but are not participating in the CAP. For example, if the payment amounts for the first year of a CAP contract are based on five successful bidders, but only four have signed contracts to supply drugs under the CAP (that is, there are four approved CAP vendors), only RNAC data collected from the four approved CAP vendors would be used to calculate the percent change in the RNAC. The average of the four approved CAP vendors' adjusted payment amounts would be used as a proxy for the RNAC of the successful bidder that is not participating in the CAP. The updated CAP payment amount would then be calculated as the median of the five data points (one data point for each approved CAP vendor's updated payment amount, and one data point calculated using the average of the approved CAP vendors' RNAC). Similarly, if there were five successful bidders but only three chose to become approved CAP vendors, the average of the three approved CAP vendors' RNAC would be the proxy for the RNAC of the two bidders who did not participate. The median of those five data points would become the updated CAP payment amount.

Our approach in the CY 2009 PFS proposed rule was intended to provide us with a flexible method for updating CAP prices, to be consistent with our original policy as stated in the July 6, 2005 IFC, and to account for bidders or approved CAP vendors who are not participating in the program at the time the price updates are calculated. However, our approach was limited in scope because it was made during a contract period and during bidding for an upcoming contract and we did not want to make any significant changes to the CAP program which could affect contractual obligations. Furthermore, we received a comment in response to the CY 2009 PFS proposed rule that suggested the elimination of the proxy procedure so that payments would be based on actual data from participating vendors and would better reflect experience within the program. After additional consideration, we believe that it would be prudent to simplify and update our 2009 proposal in order to account for successful bidders who choose not to participate in the CAP, possible changes in the number of approved CAP vendors over the life of a 3-year CAP contract, and to allow for flexibility in setting the frequency of payment amount adjustments as described in section a. above. We believe that our updated proposal is easier for the vendor community to understand and for us to implement. Furthermore, our revised proposal is not constrained by concerns about the impact of changes on an active contract.

We are proposing to clarify that the RNAC-based adjustment calculations are intended to apply only to approved CAP vendors (not all bidders), and that the most recent CAP payment amount

(for example, the previous year's or the previous quarter's payment amount) will be the starting point for making the subsequent period's adjustment. Simply put, we are proposing to eliminate the use of proxy data for bidders that are no longer participating in the program. Instead, we propose to use RNAC data only from approved CAP vendors that are participating in the CAP at the time that an RNAC-based price update is being calculated. We are also clarifying that the starting point for the payment amount adjustment is the most recent payment amount. The percent change calculated from each participating approved CAP vendor's RNAC data will be applied to the most recent payment amount by recomputing the single price using the median of all participating vendors' adjusted prices.

For example, if quarterly adjustments beginning at the start of claims processing approved CAP vendor's contract as described in section a. above are implemented, and the post bid period's CAP payment amounts are calculated based on five successful bids, but only four approved CAP vendors are participating when CAP claims processing begins, the RNAC-based payment amount adjustment for the first quarter of CAP claims would be based on RNAC data provided by the four approved CAP vendors that will be furnishing drugs under the CAP. The four approved CAP vendors would be required to submit a quarter of RNAC data within thirty days of the close of the quarter to which the data applied, prior to the beginning of CAP claims processing for the new contract. We would apply the percentage change in RNAC reported by each of the four approved CAP vendors to the CAP payment amounts calculated from successful bids, and the adjusted payment amount would be the median of those four adjusted amounts. Assuming that these four vendors are still furnishing drugs during the second quarter, calculations for the second quarter would apply the RNAC-based adjustment calculated from the four vendors' data to the first quarter's payment amount.

This process would apply to the composite bid drug list as amended by rulemaking, meaning that a single weighted percent change in RNAC is calculated for all drugs in the composite bid list and that single percent change is applied to all drugs in the list. For drugs that are bid as separate line items, such as drugs that were included in addendum B of the 2006 bidding period (*see* 70 FR 39072 and updated as addendum G in 70 FR 70238) or for drugs that are added during a contract period, each HCPCS code will be adjusted as a separate line item. Such codes will not be included in the composite, weighted drug list. Our process will continue to assign a single payment amount to all approved CAP vendors that supply a given HCPCS code; we do not intend to have more than one payment amount for any HCPCS code under the CAP or for individual ''NOC'' drugs described in § 414.906(f)(2)(iv).

This updated approach is flexible, and we believe it can accommodate a variety of scenarios, including a changing number of approved CAP vendors and changes to the frequency with which payment amount updates are made. It provides a straightforward and accurate clarification of the price adjustment mechanism described in regulation text. We believe that this proposal remains consistent with our original preamble language and with our CY 2009 PFS proposal, because it retains the two-step calculation using the percent change in RNAC. Finally, we believe that our approach will eliminate any perception that nonparticipating vendors can significantly affect CAP payment amount adjustments. We welcome comments on our proposal and corresponding regulation text changes at § 414.906(c).

g. 2009 PFS Proposals

(1) Definition of a CAP Physician

In the July 6, 2005 IFC, we stated that section 1847B of the Act most closely describes a system for the provision of and the payment for drugs provided incident to a physician's service (70 FR 39026). In the November 21, 2005 IFC (70 FR 70258), we stated that for the purposes of the CAP, a physician includes all practitioners that meet the definition of a ''physician'' in section 1861(r) of the Act. This definition includes doctors of medicine, osteopathy, dental surgery, dental medicine, podiatry, and optometry, as well as chiropractors. However, this definition does not include other health care professionals, such as nurse practitioners (NPs), clinical nurse specialists (CNSs), and other professions such as physician assistants (PAs) who may be able to legally prescribe medications and enroll in Medicare. Our 2005 CAP definition was not intended to exclude these practitioners who are appropriately billing Medicare for legally prescribed medications administered in a capacity that would be classified as incident to a physician's services if the medications were administered by a physician. We are concerned that the existing CAP definition of a physician is unnecessarily restrictive and could potentially affect access to the CAP for a small segment of providers that should be eligible for participation in the CAP in situations where they currently bill Medicare separately and appropriately.

In the CY 2009 PFS proposed rule (73 FR 38523), we proposed to further clarify that, for the purposes of the CAP, the definition of a physician included all practitioners that meet the definition of a ''physician'' in section 1861(r) of the Act, as well as practitioners (such as NPs, CNSs and PAs) described in section 1861(s)(2)(K) of the Act and other practitioners who legally prescribe drugs associated with services under section 1861(s) of the Act if those services and the associated drugs are covered when furnished incident to a physician's service. While we believed that most practitioners described in section 1861(s)(2)(K) of the Act would bill under specific physician provider numbers, it was not our intent to exclude practitioners who are able to bill independently for drugs associated with services that are covered when provided by a physician and legally authorized to be performed.

In response to our CY 2009 proposed rule, only a few commenters were concerned about the inclusion of inadequately trained practitioners and risks to patient safety under this expanded definition. Another commenter stated that this definition goes beyond the scope of the provisions in the MMA and the strict definition of ''physician'' in the statute. However, the majority of comments supported this proposal.

We did not receive any feedback during the CAP postponement that would lead us to reconsider this proposal. Therefore, we are again proposing to further clarify that, for the purposes of the CAP, the definition of a physician included all practitioners that meet the definition of a ''physician'' in section 1861(r) of the Act, as well as practitioners (such as NPs, CNSs and PAs) described in section 1861(s)(2)(K) of the Act and other practitioners who legally prescribe drugs associated with services under section 1861(s) of the Act if those services and the associated drugs are covered when furnished incident to a physician's services.

Our proposal is specific to the Part B Drug CAP and does not affect the definition of physician in section 1861(r) of the Act, or the definition of ''Medical and Other Health Services'' described in section 1861(s) of the Act. This proposal also does not seek to expand the scope of the CAP beyond

what has been described in previous rules, other than to clarify that a small number of providers who are enrolled in Medicare, and who legally prescribe drugs associated with services under section 1861(s) of the Act and can be paid by Medicare may elect to participate in the CAP if billing independently. In short, the CAP remains a program that provides Part B drugs furnished incident to a physician's services. We welcome additional comments on the proposal.

(2) Easing the Restriction on Physicians Transporting CAP Drugs

Although section 1847B(b)(4)(E) of the Act provides for the shipment of CAP drugs to settings other than a participating CAP physician's office under certain conditions, in initially implementing the CAP, we did not propose to implement the CAP in alternative settings. We implemented the CAP with a restriction that CAP drugs be shipped directly to the participating CAP physician, as stated in § 414.906(a)(4), and that participating CAP physicians may not transport CAP drugs from one location to another, as stated in § 414.908(a)(3)(xii). However, we were aware that physicians may desire to administer drugs in alternative settings. Therefore, in the July 6, 2005 IFC, we sought comment on how this could be accommodated under the CAP in a way that addresses the potential vendors' concerns about product integrity and damage to the approved CAP vendors' property (70 FR 39048). We discussed comments submitted in response to the July 6, 2005 IFC in the CY 2008 PFS proposed rule (72 FR 38158). We also requested comments in the CY 2008 PFS proposed rule (72 FR 38157) on the potential feasibility of easing the restriction on transporting CAP drugs where this is permitted by State law and other applicable laws and regulations. We responded to submitted comments in the CY 2008 PFS final rule with comment period (72 FR 66268).

In the CY 2009 PFS proposed rule (70 FR 38523), we proposed to permit the transportation of CAP drug between a participating CAP physician's practice locations subject to voluntary agreements between the approved CAP vendor and the participating CAP physician. Because of the 2009 CAP postponement, we did not address this issue in the CY 2009 PFS final rule. However, we did receive the following comments in response to our proposed rule on easing transportation restrictions in the CAP:

- Many commenters indicated that this change would increase program flexibility and facilitate patient treatment.
- Some commenters were supportive, but also raised concerns about drug integrity and liability, and requested that appropriate safeguards be in place before transportation restrictions were eased.
- Generally, commenters wanted CMS to explicitly delineate standards about voluntary agreements that address concerns about product integrity, liability, transportation procedures, and documentation. One commenter indicated that such standards should be developed through a separate rulemaking period to allow for public comment.
- Several commenters cited State pedigree laws as possible impediments to physician transport of drugs.

We also requested and received feedback about the program during the 2009 postponement period. One member of the potential vendor community urged us to be mindful of increased legal liability for an approved CAP vendor if this policy were to be implemented, but also acknowledged that the proposal might substantially increase physician interest in the program.

We continue to be mindful of the concerns expressed by the commenters, and have evaluated both the advantages and disadvantages of easing the restriction on transportation of CAP drugs. Thus, we are again proposing to permit transport of CAP drug between a participating CAP physician's practice locations subject to voluntary agreements between the approved CAP vendor and the participating CAP physician. As indicated in our CY 2009 PFS proposed rule, we continue to propose that such agreements must comply with all applicable State and Federal laws and regulations and product liability requirements, and be documented in writing.

We would again like to reiterate the voluntary nature of these proposed agreements. Approved CAP vendors would not be required to offer and participating CAP physicians would not be required to accept such agreements when selecting an approved CAP vendor. An approved CAP vendor may not refuse to do business with a participating CAP physician because the participating CAP physician has declined to enter into such an agreement with the approved CAP vendor. Furthermore, we are not seeking to define which CAP drugs may be subject to the proposed voluntary agreements. In other words, each approved CAP vendor could specify which CAP drug(s) could be transported.

However, our proposal continues to contain certain limitations. In previous rulemaking, we have described requirements for voluntary agreements between approved CAP vendors and participating CAP physicians. In the July 6, 2005 IFC (70 FR 39050) and the CY 2006 PFS final rule (70 FR 70251 through 70252), we stated that we will not dictate the breadth of use or the specific obligations contained in voluntary arrangements between approved CAP vendors and participating CAP physicians, other than to note that they must comply with applicable law and to prohibit approved CAP vendors from coercing participating CAP physicians into entering any of these arrangements. Parties to such arrangements must also ensure that the arrangements do not violate the physician self-referral (''Stark'') prohibition (section 1877 of the Act), the Federal anti-kickback statute (section 1128B(b) of the Act), or any other Federal or State law or regulation governing billing or claims submission. We are proposing to apply these standards to any agreement for the transport of CAP drugs.

We remain concerned about opportunities for disruption in the drug's chain of custody and appropriate storage and handling conditions that may ultimately affect patient care or increase the risk of drug theft or diversion. Therefore, in order to maintain safety and drug integrity in the CAP and to protect against the fraudulent diversion of CAP drugs, we are reproposing that any voluntary agreements between an approved CAP vendor and a participating CAP physician regarding the transportation of CAP drug must include requirements that drugs are not subjected to conditions that will jeopardize their integrity, stability, and/or sterility while being transported. We again welcome comments on these issues, including the identification of who may transport the drugs, how documentation of transportation activities could be accomplished, and how the oversight of such agreements will be carried out.

In conclusion, we believe that this proposal to ease the restriction on transporting CAP drugs between a participating CAP physician's practice locations—when agreed upon by the participating CAP physician and the approved CAP vendor—will make the CAP more flexible and ultimately more appealing to participating CAP physicians. Additionally, we believe that this proposal will facilitate the participation of CAP physicians who

have office locations in rural areas and/or have satellite offices with limited hours. Moreover, we believe that this proposal will promote beneficiary care, particularly for beneficiaries who live in rural locations. Since participating CAP physicians would be able to transport CAP drugs to another office location in accordance with a voluntary agreement with their approved CAP vendor, beneficiaries would have more flexibility in scheduling the location of their appointments. We invite comments about this proposal.

(3) Dispute Resolution Process

In the CY 2009 PFS proposed rule (73 FR 38524 through 38525), we discussed two changes to the CAP dispute resolution process. Section 1847B(b)(2)(A)(ii)(II) of the Act requires an approved CAP vendor to have a grievance and appeals process for the resolution of disputes. In the July 6, 2005 IFC (70 FR 39054 through 39058), we described the process for the resolution of participating CAP physicians' drug quality and service complaints and approved CAP vendors' complaints regarding noncompliant participating CAP physicians. We encouraged participating CAP physicians, beneficiaries, and vendors to use informal communication as a first step to resolve service-related administration issues. However, we recognized that certain disputes would require a more structured approach, and therefore, we established processes under § 414.916 and § 414.917.

(i) Approved CAP Vendor's Status During the Reconsideration Process

Section 414.917 outlines the dispute resolution process for participating CAP physicians. As discussed in the July 6, 2005 IFC (70 FR 39057 through 39058), if a participating CAP physician finds an approved CAP vendor's service or the quality of a CAP drug supplied by the approved CAP vendor to be unsatisfactory, then the physician may address the issues first through the approved CAP vendor's grievance process, and second through an alternative dispute resolution process administered by the designated carrier and CMS. In turn, the designated carrier would gather information about the issue as outlined in § 414.917(b)(2) and make a recommendation to CMS on whether the approved CAP vendor has been meeting the service and quality obligations of its CAP contract. We would then review and act on that recommendation after gathering any necessary, additional information from the participating CAP physician and approved CAP vendor. If we suspend an approved CAP vendor's CAP contract for noncompliance or terminate the CAP contract in accordance with § 414.914(a), the approved CAP vendor may request a reconsideration in accordance with § 414.917(c).

In the July 6, 2005 IFC (70 FR 39058), we indicated that the approved CAP vendor's participation in the CAP would be suspended while the approved CAP vendor's appeal of our decision is pending. This suspended status is also implied in § 414.917(c)(9), which states that the ''approved CAP vendor may resume participation in CAP'' if the final reconsideration determination is favorable to the approved CAP vendor. In order to improve the clarity of our regulations, we proposed in the CY 2009 PFS proposed rule that the approved CAP vendor's contract will remain suspended during the reconsideration period in § 414.917 (73 FR 38525). We believed that this proposed technical change is consistent with basic contracting concepts and with our current practices for the CAP. This proposal was not finalized due to the 2009 CAP postponement.

Comments submitted in response to our CY 2009 PFS proposed rule supported this proposed clarification and we did not receive additional feedback about this issue after the CAP was postponed. Based on this and our continued need to improve the clarity of our regulations, we are reproposing that the approved CAP vendor's contract will remain suspended during the reconsideration period in § 414.917. We invite additional comments regarding this proposed issue.

(ii) Termination of CAP Drug Shipments to Suspended CAP Physicians

Section 414.916 provides a mechanism for approved CAP vendors to address noncompliance problems with participating CAP physicians. As stated at § 414.916(a), ''Cases of an approved CAP vendor's dissatisfaction with denied drug claims are resolved through a voluntary alternative dispute resolution process delivered by the designated carrier, and a reconsideration process provided by CMS.'' Once the decision is made to suspend a participating CAP physician's CAP election agreement, the participating CAP physician will be suspended from the CAP as described in § 414.916(b)(3).

Physicians whose participation in the CAP has been suspended are not eligible to receive CAP drugs. This is implied in § 414.906(a)(4), which speaks of approved CAP vendors providing CAP drugs directly to ''[a] participating CAP physician.'' However, we believe that the clarity of our dispute resolution regulations would be improved if this drug delivery issue were stated explicitly. Therefore, in the CY 2009 PFS proposed rule, we proposed to revise § 414.916 to specify that approved CAP vendors shall not deliver CAP drugs to participating CAP physicians whose participation in the CAP has been suspended after an initial determination by CMS. Our proposal also applied to physicians engaged in the reconsideration process outlined in § 414.916(c) and included a conforming change at § 414.914(f)(12). We believed that these changes were in accord with the underlying intent of § 414.916, namely to provide a mechanism for approved CAP vendors to address noncompliance problems with participating CAP physicians, and we believe that these changes will increase the clarity of our regulations. We also noted that the participating CAP physicians who are suspended from participation in the CAP will be able to obtain drugs and bill for them under the ASP payment system provided they have not been excluded from participation in Medicare and/or their billing privileges have not been revoked.

Comments submitted in response to the CY 2009 PFS proposed rule agreed with our proposal. Though we did not finalize this proposal due to the 2009 CAP postponement, we received no comments from the public in response to our request for feedback during the CAP 2009 postponement. Based on positive public feedback and our continued belief that the clarity of our dispute resolution regulations would be improved by being explicit about this issue, we are reproposing to revise § 414.916 to specify that approved CAP vendors shall not deliver CAP drugs to participating CAP physicians whose participation in the CAP has been suspended after an initial determination by CMS. This suspension in drug shipment would also apply to physicians engaged in the reconsideration process outlined in § 414.916(c). We have also proposed a conforming change to § 414.914(f)(12). Physicians who are suspended from participation in the CAP will be able to obtain drugs and bill for them under the ASP payment system provided they have not been excluded from participation in Medicare and/or their billing privileges have not been revoked. We welcome comments on this proposal.

I. Provisions Related to Payment for Renal Dialysis Services Furnished by End-Stage Renal Disease (ESRD) Facilities

Since August 1, 1983, payment for dialysis services furnished by end-stage renal disease (ESRD) facilities has been based on a composite rate payment system that provides a fixed, prospectively determined amount per dialysis treatment, adjusted for geographic differences in area wage levels. In accordance with section 1881(b)(7) of the Act, separate composite rates were established for hospital-based and independent ESRD facilities. The composite rate is designed to cover a package of goods and services needed to furnish dialysis treatments that include, but not be limited to, certain routinely provided drugs, laboratory tests, supplies, and equipment. Unless specifically included in the composite rate, other injectable drugs and laboratory tests medically necessary for the care of the dialysis patient are separately billable. Effective on August 1, 1983, the base composite rates per treatment were $123 for independent ESRD facilities and $127 for hospital-based ESRD facilities. The Congress has enacted a number of adjustments to the composite rate since that time.

Section 623 of the MMA amended section 1881 of the Act to require changes to the composite rate payment methodology, as well as to the pricing methodology for separately billable drugs and biologicals furnished by ESRD facilities. Section 1881(b)(12) of the Act, as added by section 623(d) of the MMA, requires the establishment of a basic case-mix adjusted composite payment system that includes services comprising the composite rate and an add-on to the composite rate component to account for the difference between current payments for separately billed drugs and the revised drug pricing specified in the statute. In addition, section 1881(b)(12) of the Act requires that the composite rate be adjusted for a number of patient characteristics (case-mix) and section 1881(b)(12)(D) of the Act gives the Secretary discretion to revise the wage indices and the urban and rural definitions used to develop them. Finally, section 1881(b)(12)(E) of the Act imposes a budget neutrality (BN) adjustment, so that aggregate payments under the basic case-mix adjusted composite payment system for CY 2005 equal the aggregate payments for the same period if section 1881(b)(12) of the Act did not apply.

Before January 1, 2005, payment to both independent and hospital-based facilities for the anti-anemia drug, erythropoietin (EPO) was established under section 1881(b)(11) of the Act at $10.00 per 1,000 units. For independent ESRD facilities, payment for all other separately billable drugs and biologicals is based on the lower of actual charges or 95 percent of the average wholesale price (AWP). Hospital-based ESRD facilities were paid based on the reasonable cost methodology for separately billed drugs and biologicals (other than EPO) furnished to dialysis patients. Changes to the payment methodology for separately billed ESRD drugs and biologicals that were established by the MMA affected payments in both CY 2005 and CY 2006.

1. CY 2005 Revisions

In the CY 2005 PFS final rule with comment period (69 FR 66319 through 66334), we implemented section 1881(b) of the Act, as amended by section 623 of the MMA, and revised payments to ESRD facilities. These revisions were effective January 1, 2005, and included an update of 1.6 percent to the composite rate component of the payment system; and a drug add-on adjustment of 8.7 percent to the composite rate to account for the difference between pre-MMA payments for separately billable drugs and payments based on revised drug pricing for 2005 which used acquisition costs. Effective April 1, 2005, the CY 2005 PFS final rule with comment period also implemented case-mix adjustments to the composite rate for certain patient characteristics (that is, age, low body mass index, and body surface area).

In addition, to implement section 1881(b)(13) of the Act, we revised payments for drugs billed separately by independent ESRD facilities, paying for the top 10 ESRD drugs based on acquisition costs (as determined by the OIG) and for other separately billed drugs at the average sales price +6 percent (hereafter referred to as ASP+6 percent). Hospital-based ESRD providers continued to receive cost-based payments for all separately billable drugs and biologicals except for EPO which was paid based on average acquisition cost.

2. CY 2006 Revisions

In the CY 2006 PFS final rule with comment period (70 FR 70161), we implemented additional revisions to payments to ESRD facilities under section 623 of the MMA. For CY 2006, we further revised the drug payment methodology applicable to drugs furnished by ESRD facilities. All separately billed drugs and biologicals furnished by both hospital-based and independent ESRD facilities are now paid based on ASP+6 percent.

We recalculated the 2005 drug add-on adjustment to reflect the difference in payments between the pre-MMA AWP pricing and the revised pricing based on ASP+6 percent. The recalculation did not affect the actual add-on adjustment applied to payments in 2005, but provided an estimate of what the adjustment would have been had the 2006 payment methodology been in effect in CY 2005. The drug add-on adjustment was then updated to reflect the expected growth in expenditures for separately billable drugs in CY 2006.

As of January 1, 2006, we also implemented a revised geographic adjustment authorized by section 1881(b)(12) of the Act. As part of that change, we—

- Revised the labor market areas to incorporate the Core-Based Statistical Area (CBSA) designations established by the Office of Management and Budget (OMB);
- Eliminated the wage index ceiling and reduced the floor to 0.8500; and
- Revised the labor portion of the composite rate to which the geographic adjustment is applied.

We also provided a 4-year transition from the previous wage-adjusted composite rates to the current wage-adjusted rates. For CY 2006, 25 percent of the payment was based on the revised geographic adjustments, and the remaining 75 percent of payment was based on the old metropolitan statistical area-based (MSA-based) payments.

In addition, section 5106 of the DRA provided for a 1.6 percent update to the composite rate component of the basic case-mix adjusted composite payment system, effective January 1, 2006. As a result, the base composite rate was increased to $130.40 for independent ESRD facilities and $134.53 for hospital-based providers. For 2006, the drug add-on adjustment (including the growth update) was 14.5 percent.

3. CY 2007 Updates In the CY 2007 PFS final rule with comment period (71 FR 69681), we implemented the following updates to the basic case-mix adjusted composite payment system:

- An update to the wage index adjustments to reflect the latest hospital wage data, including a BN adjustment of 1.052818 to the wage index for CY 2007.
- A method to annually calculate the growth update to the drug add-on adjustment required by section 1881(b)(12) of the Act, as well as a growth update to the drug add-on adjustment of 0.5 percent for CY 2007. Therefore, effective January 1, 2007 the

drug add-on adjustment was increased to 15.1 percent.

In addition, section 103 of the MIEA-TRHCA established a 1.6 percent update to the composite rate portion of the payment system, effective April 1, 2007. As a result, the current base composite rate was $132.49 for independent facilities and $136.68 for hospital-based providers. Also, the effect of this increase in the composite rate portion of the payment system was a reduction in the drug add-on adjustment to 14.9 percent, effective April 1, 2007. Since the statutory increase only applied to the composite rate, an adjustment to the drug add-on percent was needed to maintain the drug add-on amount constant.

4. CY 2008 Updates

In the CY 2008 PFS final rule with comment period (72 FR 66280), we implemented the following updates to the basic case-mix adjusted payment system:

- A growth update to the drug add-on adjustment of 0.5 percent. As a result, the drug add-on adjustment to the composite payment rate increased from 14.9 percent to 15.5 percent.
- An update to the wage index adjustments to reflect the latest hospital wage data, including a wage index BN adjustment of 1.055473 to the wage index for CY 2008.

For CY 2008, consistent with the transition blends announced in the CY 2006 PFS final rule with comment period (70 FR 70170), we implemented the third year of the transition to the CBSA-based wage index. In addition, the wage index floor was reduced from 0.8000 to 0.7500. After applying the wage index BN adjustment of 1.055473, the wage index floor was 0.7916.

5. CY 2009 Updates

Subsequent to the July 7, 2008 publication of the CY 2009 PFS proposed rule, section 153 of the MIPPA mandated changes in ESRD payment including a 1 percent increase to the composite rate, effective for services furnished on or after January 1, 2009 and 2010 and before January 1, 2010.

Specifically, section 153(a) of the MIPPA updated sections 1881(b)(12)(G) and 1881(b)(12)(A) of the Act to revised payments to ESRD facilities. The revisions that were effective January 1, 2009, included the update of 1 percent to the composite rate component of the payment system noted above, and the establishment of a site neutral composite rate for both hospital-based and independent dialysis facilities that reflected the labor share based on the labor share otherwise applied to independent dialysis facilities. The labor share for both hospital-based and independent dialysis facilities was 53.711. In the CY 2009 final rule with comment period (73 69754 through 69761), we implemented the following updates to the basic case-mix adjusted composite payment system:

- As required by updated sections 1881(b)(12)(G) and 1881(b)(12)(A) of the Act, we applied a 1 percent increase to the independent dialysis facility's CY 2008 composite rate of $132.49, which resulted in a CY 2009 base composite rate for both hospital-based and independent dialysis facilities of $133.81;
- A zero growth update to the drug add-on adjustment of 15.2 percent to the composite rates for 2009 as required by section 1881(b)(1)(F) of the Act (resulted in a $20.33 per treatment drug add-on amount);

Prior to MIPPA, the proposed drug add-on adjustment was 15.5 percent. Since we compute the drug add-on adjustment as a percentage of the weighted average base composite rate, the effect of the one percent increase in the composite rate portion of the payment system, effective January 1, 2009, reduced the drug add-on adjustment from 15.5 to 15.2 percent. Since the statutory increase only applied to the composite rate, this adjustment to the drug add-on percent was needed to ensure that the total drug add-on dollars remained constant.

- An update to the wage index adjustment to reflect the latest available wage data, including a wage index BN adjustment of 1.056672 to the wage index for CY 2009;
- For CY 2009, the completion of the 4-year transition from the previous wage-adjusted composite rates to the CBSA wage-adjusted rates, where payment is based on 100 percent of the revised geographic adjustments; and
- A reduction of the wage index floor from 0.7500 to 0.7000. After applying the wage index BN adjustment of 1.056672, the wage index floor was 0.7397.

6. CY 2010 Proposals

For CY 2010, we are proposing the following updates to the composite rate payment system:

- An update to the drug add-on adjustment to the composite rate, using a refined methodology for projecting growth in drug expenditures;
- An update to the wage index adjustment to reflect the latest available wage data, including a revised BN adjustment; and
- A reduction to the ESRD wage index floor from 0.7000 to 0.6500.

As stated above, section 1881(b)(12)(G)(iv) of the Act, as added by section 153(a)(1) of the MIPPA, increased the composite rate by 1.0 percent for ESRD services furnished on or after January 1, 2010. The 1.0 percent increases the current composite rate of $133.81 to $135.15 for services furnished on or after January 1, 2010.

a. Proposed Update to the Drug Add-on Adjustment to the Composite Rate

Section 623(d) of the MMA added section 1881(b)(12)(B)(ii) of the Act which requires establishing an add-on to the composite rate to account for changes in the drug payment methodology stemming from enactment of the MMA. Section 1881(b)(12)(C) of the Act provides that the drug add-on must reflect the difference in aggregate payments between the revised drug payment methodology for separately billable ESRD drugs and the AWP payment methodology. In 2005, we generally paid for ESRD drugs based on average acquisition costs. Thus the difference from AWP pricing was calculated using acquisition costs. However, in 2006 when we moved to ASP pricing for ESRD drugs, we recalculated the difference from AWP pricing using ASP prices.

In addition, section 1881(b)(12)(F) of the Act requires that, beginning in CY 2006, we establish an annual increase to the drug add-on to reflect estimated growth in expenditures for separately billable drugs and biologicals furnished by ESRD facilities. This growth update applies only to the drug add-on portion of the case-mix adjusted payment system. The CY 2009 drug add-on adjustment to the composite rate was 15.2 percent. The drug add-on adjustment for CY 2009 reflected a zero increase. This computation is explained in detail below and in the CY 2009 PFS final rule with comment period (73 FR 69755 through 69757).

(i) Estimating Growth in Expenditures for Drugs and Biologicals for CY 2009

Section 1881(b)(12)(F) of the Act specifies that the drug add-on increase must reflect ''the estimated growth in expenditures for drugs and biologicals (including erythropoietin) that are separately billable * * *'' By referring to ''expenditures'', we stated previously that we believe the statute contemplates that the update would account for both increases in drug prices, as well as increases in utilization of those drugs.

In the CY 2007 PFS final rule with comment period (71 FR 69682), we established an interim methodology for annually estimating the growth in ESRD drugs and biological expenditures that

uses the Producer Price Index (PPI) for pharmaceuticals as a proxy for pricing growth in conjunction with 2 years of ESRD drug data to estimate per patient utilization growth. We indicated that this interim methodology would be used to update the drug add-on to the composite rate until such time that we had sufficient ESRD drug expenditure data to project the growth in ESRD drug expenditures.

However, due to the declining ASP prices, we no longer believed that using the PPI as a proxy for pricing growth was appropriate. Accordingly, for CY 2009, we revised the interim methodology for estimating the growth in ESRD drug expenditures by using ASP pricing to estimate the price component of the update calculation. Due to the declining trend in ASP pricing and utilization, we calculated a decrease in the drug add-on adjustment, and applied a zero update to the drug add-on adjustment (73 FR 69755 through 69757).

(ii) Estimating Growth in Expenditures for Drugs and Biologicals in CY 2010

Since we now have 3 years of drug expenditure data based on ASP pricing, we have reevaluated our methodology for estimating growth in drug expenditures. We believe that 3 years of drug expenditure data based on ASP pricing is sufficient to project drug expenditure growth based on trend analysis. Therefore, for CY 2010, we are proposing to use trend analysis from drug expenditure data to update the per treatment drug add-on adjustment. In the CY 2008 PFS final rule with comment period, we stated that when we had 3 consecutive years of ASP-based historical drug expenditure data, we intended to reevaluate our methodology for estimating growth in drug add-on adjustment (72 FR 66281). We also stated that we expected 2010 would be the earliest we could consider using trend analysis to update the drug add-on adjustment (72 FR 66281).

For CY 2010, we propose to estimate per patient growth in drug expenditures by removing growth in ESRD enrollment from growth in total drug expenditures.

To estimate drug expenditure growth using trend analysis, we looked at the average annual growth in total drug expenditures between 2006 and 2008. First we had to estimate the total drug expenditures for all ESRD facilities in CY 2008. For this proposed rule, we used the final CY 2006 and the final CY 2007 ESRD claims data and the latest available CY 2008 ESRD facility claims, updated through December 31, 2008 (that is, claims with dates of service from January 1 through December 31, 2008, that were received, processed, paid, and passed to the National Claims History File as of December 31, 2008). For the CY 2010 PFS final rule, we plan to use additional updated CY 2008 claims with dates of service for the same timeframe. This updated CY 2008 data file will include claims received, processed, paid, and passed to the National Claims History File as of June 30, 2009.

While the December 2008 update of CY 2008 claims used in this proposed rule is the most current available claims data, we recognize that it does not reflect a complete year, as claims with dates of service towards the end of the year have not all been processed. To more accurately estimate the update to the drug add-on, aggregate drug expenditures are required. Based on an analysis of the 2007 claims data, we inflated the CY 2008 drug expenditures to estimate the June 30, 2009 update of the 2008 claims file. We used the relationship between the December 2007 and the June 2008 versions of 2007 claims to estimate the more complete 2008 claims that will be available in June 2009 and applied that ratio to the 2008 claims data from the December 2008 claims file. In previous years, we did this separately for EPO, the other top 10 Part B separately billable drugs, and the remaining separately billable drugs for independent and hospital-based ESRD facilities. All components were then combined to estimate aggregate CY 2008 ESRD drug expenditures. However, we do not believe that creating this estimate using this level of detail (by separately estimating EPO, the other top 10 separately billable drugs, and the remaining separately billable drug for independent and hospital-based ESRD facilities and then combining these components) provides more accuracy. For this reason, we are making this adjustment in aggregate for all separately billable drugs for CY 2008 ESRD drug expenditures. The net adjustment to the CY 2008 claims data is an increase of 11.1 percent to the 2008 expenditure data. This adjustment allows us to more accurately compare the 2007 and 2008 drug expenditure data to estimate per patient growth. As stated earlier in this section, we plan to use additional updated CY 2008 claims in the CY 2010 PFS final rule with comment period. We also note that the top 11 drugs continue to represent 99.7 percent of total expenditures in CY 2008 for separately billable drugs furnished to ESRD patients.

Using the full-year 2008 drug expenditure figure, we calculated the average annual change in drug expenditures from 2006 through 2008. This average annual change showed a decrease of 2.2 percent for this timeframe. We propose to use this 2.2 percent decrease to project drug expenditures for both 2009 and 2010.

(iii) Estimating Per Patient Growth

Once we had the projected growth in drug expenditures from 2009 to 2010, we then removed growth in enrollment for the same time period from the expenditure growth, so that the residual reflects per patient expenditure growth, (which includes price and utilization combined) which is what we believe that section 1881(b)(12)(F) of the Act requires us to use to update the drug add-on adjustment. As we described in section II.I.6.a.(ii) of this proposed rule, we now have 3 years of drug expenditure data based on ASP pricing, and for CY 2010 we are proposing to use trend analysis from this data to update the per treatment drug add-on adjustment. To calculate the per patient growth between CYs 2009 and 2010, we removed the enrollment component by using the estimated growth in enrollment data between CY 2009 and CY 2010. This was approximately 1.3 percent. To do this, we divided the total drug expenditure change between 2009 and 2010 (1.000–0.222 = 0.978) by enrollment growth of 1.3 percent (1.013) for the same timeframe. The result is a per patient growth factor equal to 0.965, (0.978/1.013 = 0.965). Thus we are projecting a 3.5 percent decrease in per patient growth in drug expenditures between 2009 and 2010.

b. Applying the Proposed Growth Update to the Drug Add-On Adjustment

In CY 2006, we applied the projected growth update percentage to the total amount of drug add-on dollars established for CY 2005 to establish a dollar amount for the CY 2006 growth update. In addition, we projected the growth in dialysis treatments for CY 2006 based on the projected growth in ESRD enrollment. We divided the projected total dollar amount of the CY 2006 growth by the projected growth in total dialysis treatments to develop the per treatment growth update amount. This growth update amount, combined with the CY 2005 per treatment drug add-on amount, resulted in an average drug add-on amount per treatment of $18.88 (or a 14.5 percent adjustment to the composite rate) for CY 2006.

In the CY 2007 PFS final rule with comment period (71 FR 69684), we revised our update methodology by applying the growth update to the per treatment drug add-on amount. That is, for CY 2007, we applied the growth

update factor of 4.03 percent to the $18.88 per treatment drug add-on amount for an updated amount of $19.64 per treatment (71 FR 69684). For CY 2008, the per treatment drug add-on amount was updated to $20.33. In the CY 2009 PFS final rule with comment period (73 FR 69755 through 69757), we applied a zero update to per treatment drug add-on amount which left it at $20.33. As discussed in detail below, for CY 2010, we are again proposing no update to the per treatment drug add-on amount of $20.33 established in CY 2008.

c. Proposed Update to the Drug Add-on Adjustment

As discussed previously in this section, we estimate a 2.2 percent reduction in drug expenditures between CY 2009 and CY 2010. Combining this reduction with a 1.3 percent increase in enrollment, as described in section (a)(iii) above, we are projecting a 3.5 percent decrease in per patient growth of drug expenditures between CY 2009 and CY 2010. Therefore, we are projecting that the combined growth in per patient utilization and pricing for CY 2010 would result in a negative update equal to −3.5 percent. However, similar to last year and as indicated above, we are proposing a zero update to the drug add-on adjustment.

We believe this approach is consistent with the language under section 1881(b)(12)(F) of the Act which states in part that ''the Secretary shall annually increase'' the drug add-on amount based on the growth in expenditures for separately billed ESRD drugs. Our understanding of the statute contemplates ''annually increase'' to mean a positive or zero update to the drug add-on. Therefore, we propose to apply a zero update, and to maintain the $20.33 per treatment drug add-on amount for CY 2010. The current $20.33 per treatment drug add-on reflected a 15.2 percent drug add-on adjustment to the composite rate in effect for CY 2009. Given that the MIPPA mandates a 1 percent increase to the composite rate (effective January 1, 2010), however, as discussed earlier in this section, this results in a decrease in the CY 2009 drug add-on adjustment of 15.2 to 15.0 to keep the drug add-on at $20.33. Therefore, we are proposing that the drug add-on adjustment to the composite rate for CY 2010 is 15.0 percent.

d. Proposed Update to the Geographic Adjustments to the Composite Rate

Section 1881(b)(12)(D) of the Act, as amended by section 623(d) of the MMA, gives the Secretary the authority to revise the wage indexes previously applied to the ESRD composite rate. The purpose of the wage index is to adjust the composite rates for differing wage levels covering the areas in which ESRD facilities are located. The wage indexes are calculated for each urban and rural area. In the CY 2006 PFS final rule with comment period (70 FR 70167), we announced our adoption of the OMB CBSA-based geographic area designations to develop revised urban/rural definitions and corresponding wage index values for purposes of calculating ESRD composite rates. In addition, we generally have followed wage index policies related to these definitions as used under the inpatient hospital prospective payment system (IPPS), but without regard to any approved geographic reclassification authorized under sections 1886(d)(8) and (d)(10) of the Act or other provisions that only apply to hospitals paid under the IPPS (70 FR 70167). For purposes of the ESRD wage index methodology, the hospital wage data we use is pre-classified, pre-floor hospital data and unadjusted for occupational mix.

e. Proposed Updates to Core-Based Statistical Area (CBSA) Definitions

In the CY 2006 PFS final rule with comment period (70 FR 70167), we announced our adoption of the OMB's CBSA-based geographic area designations to develop revised urban/rural definitions and corresponding wage index values for purposes of calculating ESRD composite rates. The CBSA-based geographic area designations are described in OMB Bulletin 03–04, originally issued June 6, 2003, and is available online at *http://www.whitehouse.gov/omb/bulletins/b03-04.html.* In addition, OMB has published subsequent bulletins regarding CBSA changes, including changes in CBSA numbers and titles. We wish to point out that this and all subsequent ESRD rules and notices are considered to incorporate the CBSA changes published in the most recent OMB bulletin that applies to the hospital wage index used to determine the current ESRD wage index. The OMB bulletins may be accessed online at *http://www.whitehouse.gov/omb/bulletins/index.html.*

f. Proposed Updated Wage Index Values

In the CY 2007 PFS final rule with comment period (71 FR 69685), we stated that we intended to update the ESRD wage index values annually. The ESRD wage index values for CY 2010 were developed from FY 2006 wage and employment data obtained from the Medicare hospital cost reports. As we indicated, the ESRD wage index values are calculated without regard to geographic classifications authorized under sections 1886(d)(8) and (d)(10) of the Act and utilize pre-floor hospital data that is unadjusted for occupational mix. We propose to use the same methodology for CY 2010, with the exception that FY 2006 hospital data would be used to develop the CY 2010 wage index values. For a detailed description of the development of the proposed CY 2010 wage index values based on FY 2006 hospital data, *see* the FY 2010 IPPS proposed rule (74 FR 24145). Section III.G, of the preamble to the FY 2010 IPPS proposed rule, ''Method for Computing the Proposed FY 2010 Unadjusted Wage Index'', describes the cost report schedules, line items, data elements, adjustments, and wage index computations. The wage index data affecting the ESRD composite rate for each urban and rural locale may also be accessed on the CMS Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp.* The wage data are located in the section entitled, ''FY 2010 Proposed Rule Occupational Mix Adjusted and Unadjusted Average Hourly Wage and Pre-reclassified Wage Index by CBSA.''

In the CY 2009 final rule with comment period (73 FR 69758 and 69759), we indicated that the CY 2009 was the final year of the transition period and each ESRD facility's composite payment rate would be based entirely on its applicable CBSA-based wage index value.

g. Proposed Reduction to the ESRD Wage Index Floor

In the CY 2009 PFS final rule with comment period, we stated our intention to continue to reassess the need for a wage index floor (73 FR 63758). We also stated that a gradual reduction in the floor is needed to support continuing patient access to dialysis in areas that have low wage index values, especially in Puerto Rico where the wage index values are below the current wage index floor. For CY 2010, we are proposing to reduce the wage index floor from 0.70 to 0.65. We also anticipate that we may reduce the floor gradually until full implementation of the ESRD PPS required by section 1881(b)(14) of the Act.

h. Proposed Wage index Values for Areas With No Hospital Data

In CY 2006, while adopting the CBSA designations, we identified a small number of ESRD facilities in both urban and rural geographic areas where there

are no hospital wage data from which to calculate ESRD wage index values. The affected areas were rural Puerto Rico, and the urban area of Hinesville, GA (CBSA 25980), and rural Massachusetts. For CY 2006, CY 2007, CY 2008, and CY 2009, we calculated the ESRD wage index values for those areas as follows:

- For the urban area of Hinesville, GA, we calculated the CY 2006, CY 2007, CY 2008, and CY 2009 wage index value based on the average wage index value for all urban areas within the State of Georgia.
- For rural Massachusetts, because we had not determined a reasonable wage proxy, we used the FY 2005 wage index value in CY 2006 and CY 2007. As discussed below, we adopted an alternative methodology for CYs 2008 and 2009.
- For rural Puerto Rico, because all geographic areas in Puerto Rico were subject to the wage index floor in CYs 2006 through 2009, we applied the ESRD wage index floor to rural Puerto Rico as well. We note that there are currently no ESRD facilities located in rural Puerto Rico.

For CY 2008, we adopted an alternative methodology for establishing a wage index value for rural Massachusetts and continued to apply this methodology in CY 2009. Because we used the same wage index value for 2 years with no update, we believed it was appropriate to establish a methodology which employed reasonable proxy data for rural areas (including rural Massachusetts) and also permitted annual updates to the wage index based on that proxy data. For rural areas without hospital wage data, we used the average wage index values from all contiguous CBSAs as a reasonable proxy for that rural area.

In determining the imputed rural wage index, we interpreted the term ''contiguous'' to mean sharing a border. In the case of Massachusetts, the entire rural area consists of Dukes and Nantucket Counties. We determined that the borders of Dukes and Nantucket counties are contiguous with CBSA 12700, Barnstable Town, MA and CBSA 39300, Providence-New Bedford-Fall River, RI–MA. We are proposing to use the same methodology for CY 2010. Under this methodology, the CY 2010 proposed wage index values for CBSA 12700 (Barnstable Town, MA—1.2629) and CBSA 39300 (Providence-New Bedford-Fall River, RI–MA—1.0792) averages results in an imputed proposed wage index value of 1.1711 for rural Massachusetts in CY 2010.

For rural Puerto Rico, for CY 2010, all areas in Puerto Rico that have a wage index are eligible for the proposed ESRD wage index floor of 0.65. Therefore, we propose to continue applying the proposed ESRD wage index floor of 0.65 to facilities that are located in rural Puerto Rico.

For Hinesville-Fort Stewart, GA (CBSA 25980), which is an urban area without specific hospital wage data, we propose to apply the same methodology used to impute a wage index value that we used in CY 2009. Specifically, we utilize the average wage index value for all urban areas within the State of Georgia. That results in a proposed CY 2010 wage index value of 0.9029 for the Hinesville-Fort Stewart GA CBSA.

In the CY 2009 PFS final rule with comment period (73 FR 69759 through 69760), we stated that we would continue to evaluate existing hospital wage data and possibly wage data from other sources such as the Bureau of Labor Statistics, to determine if other methodologies might be appropriate for imputing wage index values for areas without hospital wage data for CY 2010 and subsequent years. To date, no data from other sources, superior to that currently used in connection with the IPPS wage index has emerged. Therefore, for ESRD purposes, we continue to believe this is an appropriate policy.

For CY 2010, we are proposing to use the FY 2010 wage index data (collected from cost reports submitted by hospital for cost reporting periods beginning FY 2006) to compute the ESRD composite payment rates effective beginning January 1, 2010.

i. Budget Neutrality Adjustment

Section 1881(b)(12)(E)(i) of the Act, as added by section 623(d) of the MMA, required that any revisions to the ESRD composite rate payment system as a result of the MMA provision (including the geographic adjustment) be made in a budget neutral manner. Given our application of the ESRD wage index, this means that aggregate payments to ESRD facilities in CY 2010 would be the same as aggregate payments that would have been made if we had not made any changes to the geographic adjusters. We note that this BN adjustment only addresses the impact of changes in the geographic adjustments. A separate BN adjustment was developed for the case-mix adjustments required by the MMA. As we are not proposing any changes to the case-mix measures for CY 2010, the current case-mix BN adjustment of 0.9116 would remain in effect for CY 2010. As in CY 2009, for CY 2010, we propose to apply the wage-index BN adjustment factor of 1.057888 directly to the ESRD wage index values. Because the ESRD wage index is only applied to the labor-related portion of the composite rate, we computed the BN adjustment factor based on that proportion (53.711 percent).

To compute the proposed CY 2010 wage index BN adjustment factor (1.057888), we used the FY 2006 pre-floor, pre-reclassified, non-occupational mix-adjusted hospital data to compute the wage index values, 2008 outpatient claims (paid and processed as of December 31, 2008), and geographic location information for each facility which may be found through Dialysis Facility Compare Web page on the CMS Web site at *http://www.cms.hhs.gov/DialysisFacilityCompare/.* The FY 2006 hospital wage index data for each urban and rural locale by CBSA may also be accessed on the CMS Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp.* The wage index data are located in the section entitled, ''FY 2010 Proposed Rule Occupational Mix Adjusted and Unadjusted Average Hourly Wage and Pre-Reclassified Wage Index by CBSA.''

Using treatment counts from the 2008 claims and facility-specific CY 2009 composite rates, we computed the estimated total dollar amount each ESRD provider would have received in CY 2009. The total of these payments became the target amount of expenditures for all ESRD facilities for CY 2010. Next, we computed the estimated dollar amount that would have been paid for the same ESRD facilities using the proposed ESRD wage index for CY 2010. The total of these payments became the new CY 2010 amount of wage-adjusted composite rate expenditures for all ESRD facilities. Section 153(a) of the MIPPA revised section 1881(b)(12)(G) of the Act and provided for an update of 1 percent to the composite rate component of the payment system effective January 1, 2010. We note that when computing the new CY 2010 amount, we did not include this 1 percent increase because the BN adjustment would negate the increase.

After comparing these two dollar amounts (target amount divided by the new CY 2010 amount), we calculated an adjustment factor that, when multiplied by the applicable CY 2010 ESRD wage index value, would result in aggregate payments to ESRD facilities that would remain within the target amount of composite rate expenditures. When making this calculation, the ESRD wage index floor value of 0.6500 is applied whenever appropriate. The proposed wage BN adjustment factor is 1.057888.

To ensure BN, we also must apply the BN adjustment factor to the proposed

wage index floor of 0.6500 which results in a proposed adjusted wage index floor of 0.6876 (0.6500 x 1.057888) for CY 2010.

j. ESRD Wage Index Tables

The CY 2010 ESRD wage index tables are located in Addenda F and G of this proposed rule.

J. Discussion of Chiropractic Services Demonstration

1. Background

Section 651 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173) requires the Secretary to evaluate the feasibility and advisability of expanding coverage for chiropractic services under Medicare. Under Medicare, coverage for chiropractic services is limited to manual manipulation of the spine to correct a subluxation described in section 1861(r)(5) of the Act. The demonstration expanded current Medicare coverage to include ''care for neuromusculoskeletal conditions typical among eligible beneficiaries and diagnostic and other services that a chiropractor is legally authorized to perform by the State or jurisdiction in which such treatment is provided.'' The 2-year demonstration was conducted in four geographically diverse sites, two rural and two urban regions, with each type including a Health Professional Shortage Area (HPSA). The two urban sites were 26 counties in Illinois and Scott County, Iowa, and 17 counties in Virginia. The two rural sites were the States of Maine and New Mexico. The demonstration, which ended on March 31, 2007, was required to be budget neutral as section 651(f)(1)(B) of the MMA requires the Secretary to ensure that ''the aggregate payments made by the Secretary under the Medicare program do not exceed the amount which the Secretary would have paid under the Medicare program if the demonstration projects under this section were not implemented.''

In the CY 2006, 2007, and 2008 PFS final rules with comment period (70 FR 70266, 71 FR 69707, 72 FR 66325, respectively), we included a discussion of the strategy that would be used to assess budget neutrality (BN) and how chiropractor fees would be adjusted should the demonstration result in costs higher than those that would occur in the absence of the demonstration. We stated we would assess BN by determining the change in costs based on a pre-post comparison of costs and the rate of change for specific diagnoses that are treated by chiropractors and physicians in the demonstration sites and control sites. We also stated we would not limit our analysis to reviewing only chiropractor claims because the costs of the expanded chiropractor services may have an impact on other Medicare costs. If the demonstration was not budget neutral, we anticipated making reductions in the CY 2010 and CY 2011 physician fee schedules. We proposed that if we determined that the adjustment for BN was greater than 2 percent of spending for the chiropractor fee schedule codes, we would implement the adjustment over a 2-year period. However, if the adjustment was less than 2 percent of spending under the chiropractor fee schedule codes, we would implement the adjustment over a 1-year period.

2. Analysis of Demonstration

Brandeis University, the demonstration evaluator, used two approaches in examining BN. The ''All Neuromusculoskeletal Analysis (NMS)'' reflects an intent-to-treat approach whereby the utilization of all beneficiaries who received any Medicare covered services for neuromusculoskeletal conditions in the demonstration areas was examined. This method is potentially subject to large external forces because of its inclusion of all beneficiaries including those who did not use chiropractic services and who would not become users of chiropractic services even with expanded coverage for them. Therefore, a second analysis, termed the ''Chiropractic User Analysis'' was conducted to examine only the subset of beneficiaries who used chiropractic services for the treatment of their neuromusculoskeletal conditions. Both approaches use hierarchical linear modeling of costs over 3 years—1 year prior to the demonstration and the 2 years of the demonstration. We posted a report describing these analyses on CMS Web site at *http://www.cms.hhs.gov/reports/downloads/MMA651_BudgetNeutrality.pdf*.

The results of both analyses indicate that the demonstration was not budget neutral. In the ''All NMS Analysis,'' which measured the costs of the demonstration on all beneficiaries who received services for a neuromusculoskeletal condition in the demonstration areas in comparison to beneficiaries with similar characteristics from similar geographic areas that did not participate in the demonstration, the total effect of the demonstration to Medicare was $114 million. In the ''Chiropractic User Analysis,'' which measured the costs of the demonstration among beneficiaries who used expanded chiropractic services to treat a neuromusculoskeletal condition in the demonstration areas, in comparison to beneficiaries with similar characteristics who used chiropractic services as currently covered by Medicare to treat a neuromusculoskeletal condition from similar geographic areas that did not participate in the demonstration, the total effect of the demonstration to Medicare was $50 million.

Both approaches to assessing BN have strengths and limitations. The ''All NMS Analysis'' provides the broadest view of the Medicare population that would have been eligible for the demonstration's expanded coverage of chiropractic services. Because it includes all beneficiaries with neuromusculoskeletal conditions, it guards against validity threats of selection. However, this approach creates a large heterogeneous group which may only include a small proportion of chiropractic service users. Basing estimates of BN on such a large heterogeneous group increases the potential for changes in the use of services seldom affected by chiropractors to be falsely attributed to the demonstration, which could result in the costs of the demonstration appearing to be larger than they actually were.

We believe the BN estimate should be based on the ''Chiropractic User Analysis'' because of its focus on users of chiropractic services rather than all Medicare beneficiaries with neuromusculoskeletal conditions, including those who did not use chiropractic services and who would not have become users of chiropractic services even with expanded coverage for them. Users of chiropractic services are most likely to have been affected by the expanded coverage provided by this demonstration. Cost increases and offsets, such as reductions in hospitalizations or other types of ambulatory care, are more likely to be observed in this group. Therefore, we are proposing to adjust the Medicare PFS for all chiropractors using the estimate provided in the ''Chiropractic User Analysis.''

The CMS Office of the Actuary (OACT) estimates chiropractic expenditures in CY 2010 to be approximately $487 million based on actual Medicare spending for chiropractic services for the most recent available year. Because the costs of this demonstration were higher than expected and we did not anticipate a reduction to the PFS of greater than 2 percent per year, we are proposing to recoup the $50 million in expenditures from this demonstration over a 5-year period rather than over a 2-year period.

This approach reflects a change from our BN discussion in the CY 2006, 2007, and 2008 PFS rules, which was described previously in this section. We would recoup $10 million each year through adjustments to the PFS for all chiropractors in CYs 2010 through 2014. We believe that spreading this adjustment over a longer period of time and in equal increments will minimize its potential negative impact on chiropractic practices.

3. Payment Adjustment

To implement the required BN adjustment, we propose to reduce the payment amount under the PFS for the chiropractic CPT codes (that is, CPT codes 98940, 98941, and 98942). Payment under the PFS for these codes would be reduced by 2 percent. As stated in prior PFS rules, application of the BN adjustment would be specific to these three codes which represent the ''chiropractic fee schedule'' because they are the only chiropractic codes recognized under the PFS. We are proposing to reflect this reduction only in the payment files used by the Medicare contractors to process Medicare claims rather than through adjusting the RVUs. This would preserve the integrity of the PFS, particularly since many private payers also base payment on the RVUs. The RVUs published in Addendum B and posted on our Web site would not show this reduction but would be annotated to state that the reduction resulting from the chiropractic demonstration is not reflected in the RVUs.

K. Comprehensive Outpatient Rehabilitation Facilities (CORF) and Rehabilitation Agency Issues

A Comprehensive Outpatient Rehabilitation Facility (CORF) is a Medicare provider that furnishes respiratory therapy services among other services. In § 485.70, we set forth the personnel qualifications that must be satisfied by a CORF as a condition of participation under § 485.58 and as a condition of coverage of CORF services, including personnel qualifications for respiratory therapists providing CORF respiratory therapy services.

In the CY 2009 PFS proposed rule (73 FR 38502) and subsequent final rule with comment period (73 FR 69942), we revised the definition of a respiratory therapist under § 485.70(j). The change in the definition of respiratory therapist was intended to ensure accuracy in reference to persons who are qualified to perform respiratory therapy and to ensure that language regarding these professionals is consistent with current industry requirements for education, training, and practice.

Prior to its modification by the CY 2009 PFS final rule with comment period, § 485.70(j) reflected the qualifications for ''Certified Respiratory Therapists (CRTs)'' and ''Registered Respiratory Therapists (RRTs)'' as terms commonly used by the professional industry to identify persons furnishing respiratory therapy services.

Since publication of the CY 2009 PFS final rule with comment, we have been informed by the industry that the changes made in the definition of respiratory therapist exclude a category of professional that has completed the requirements of a CRT, has completed a nationally accredited educational program that confers eligibility for the National Board for Respiratory Care (NBRC) registry exam for respiratory therapists (RTs), and is eligible to sit for the national registry examination administered by the National Board for Respiratory Care (NBRC), but has not yet passed the examination. These persons are referred to in the industry as Certified Respiratory Therapists (CRTs).

Because it is our policy that Medicare payment is available for respiratory services provided to Medicare beneficiaries in a CORF only if provided by a respiratory therapist meeting the qualifications set forth in § 485.70(j), payment is not available for respiratory services provided by CRTs in the CORF setting. We note that personnel qualifications for respiratory therapists previously set forth at § 485.70(j) prior to its modification by the CY 2009 PFS final rule with comment period did not exclude this category of personnel from the definition of respiratory therapist. We have also heard from CRTs and from CORFs that this change has limited the availability of respiratory therapy services to Medicare beneficiaries in certified CORFs, as many of these services were provided by CRTs. Thus, in modifying the definition of respiratory therapist in the CY 2009 PFS final rule with comment period, we may have inadvertently impacted access to respiratory therapy services for some Medicare beneficiaries.

Thus, we are proposing to modify the definition of respiratory therapist and to clarify the terms that are used to identify those persons who furnish respiratory services in CORFs in § 485.70(j) to include CRTs, that is those individuals who have completed a nationally accredited educational program for respiratory therapists and are eligible to sit for the national registry examination administered by the National Board for Respiratory Care (NBRC), but who have not yet passed the examination. The change in the definition we are proposing would permit CRTs to furnish respiratory therapy services to Medicare beneficiaries in the CORF setting.

In this proposed rule, we intend to assure that persons who were qualified to furnish respiratory therapy services to patients in CORFs prior to the finalization of CY 2009 PFS final rule with comment period (73 FR 69942), will continue to qualify to furnish RT services to CORF patients under this proposed rule.

We invite public comment on the proposed change to § 485.70(j). We are also seeking comments from the industry regarding the difference in services furnished by the different levels of professionals who provide RT services in CORFs. We welcome such comments to be descriptive and both quantitative and qualitative in nature to the extent possible.

L. Ambulance Fee Schedule: Technical Correction to the Rural Adjustment Factor Regulations (§ 414.610)

Section 1834(l)(9) of the Act provides that for ''ground ambulance services furnished on or after July 1, 2001, and before January 1, 2004, for which transportation originates in a rural area * * * or in a rural census tract of a metropolitan statistical area * * * the fee schedule established under this subsection shall provide that, with respect to the payment rate for mileage for a trip above 17 miles, and up to 50 miles, the rate otherwise established shall be increased by not less than ½ of the additional payment per mile established for the first 17 miles of such a trip originating in a rural area.'' Thus, the statute authorized a rural mileage bonus for miles 18 through 50 for ground ambulance services furnished on or after July 1, 2001 and prior to January 1, 2004. This provision was implemented in § 414.610(c)(5)(i), but the regulation text does not currently specify the statutory time period during which this rural mileage bonus was effective. In the ''Medicare Program; Coverage and Payment of Ambulance Services; Inflation Update for CY 2004'' final rule with comment period (68 FR 67960, 67961), we acknowledged that we inadvertently omitted from the regulation text the time period during which this statutory adjustment was applicable, and stated we were ''revising § 414.610(c) to reflect that this bonus payment applies only for services furnished during the statutory period.'' Thus, in the ''Medicare Program; Coverage and Payment of Ambulance Services; Inflation Update for CY 2004'' final rule with comment period, we

revised the regulation to include the time period during which the adjustment is applicable (68 FR 67963). However, the revised language specifying the statutory time period was dropped inadvertently from the regulation text when § 414.610(c)(5) was later republished in the ''Medicare Program; Medicare Ambulance MMA Temporary Rate Increases Beginning July 1, 2004'' interim final rule (69 FR 40288, 40292).

In this proposed rule, we are reinstating the language that was originally finalized in ''Medicare Program; Coverage and Payment of Ambulance Services; Inflation Update for CY 2004'' final rule with comment period (68 FR 67963) but then inadvertently omitted again when § 414.610(c)(5) was later republished, so that § 414.610(c)(5)(i) correctly sets forth the statutory time period during which this rural mileage bonus was applicable. This revision to the regulation is a technical correction to conform the regulation to the statute. For further information, *see* program instruction, Transmittal AB–03–110; Date August 1, 2003; Change Request 2767 which was issued to inform contractors to discontinue paying such bonuses effective January 1, 2004 in accordance with the statute.

M. Clinical Laboratory Fee Schedule: Signature on Requisition

In the March 10, 2000 **Federal Register**, we published the ''Medicare Program; Negotiated Rulemaking: Coverage and Administrative Policies for Clinical Diagnostic Laboratory Services'' proposed rule (65 FR 13082) announcing and soliciting comments on the results of our negotiated rulemaking committee tasked to establish national coverage and administrative policies for clinical diagnostic laboratory tests under Part B of Medicare. In our final rule published in the November 23, 2001 **Federal Register** (66 FR 58788), we explained our policy on ordering clinical diagnostic laboratory services and amended § 410.32 to make our policy more explicit. Our regulation at § 410.32(a) included the requirement that ''[a]ll diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician who is treating the beneficiary.'' In the November 23, 2001 final rule, we added paragraph (d)(2) to § 410.32 to require that the physician or qualified nonphysician practitioner (NPP) who orders the service must maintain documentation of medical necessity in the beneficiary's medical record (66 FR 58809). In the preamble discussions to the March 10, 2000 proposed rule and November 23, 2001 final rule (65 FR 13089 and 66 FR 58802, respectively), we noted that ''[w]hile the signature of a physician on a requisition is one way of documenting that the treating physician ordered the test, it is not the only permissible way of documenting that the test has been ordered.'' In those preambles, we described the policy of not requiring physician signatures on requisitions for clinical diagnostic laboratory tests, but implicitly left in place the existing requirements for a written order to be signed by the ordering physician or NPP for clinical diagnostic laboratory tests, as well as other types of diagnostic tests. We further stated in the preambles of the proposed and final rules that we would publish an instruction to Medicare contractors clarifying that the signature of the ordering physician is not required for Medicare purposes on a requisition for a clinical diagnostic laboratory test (65 FR 13089 and 66 FR 58802).

On March 5, 2002, we published a program transmittal implementing the administrative policies set forth in the final rule, including the following instruction: ''Medicare does not require the signature of the ordering physician on a laboratory service requisition. While the signature of a physician on a requisition is one way of documenting that the treating physician ordered the service, it is not the only permissible way of documenting that the service has been ordered. For example, the physician may document the ordering of specific services in the patient's medical record.'' (Transmittal AB–02–030, Change Request 1998, dated March 5, 2002).

On January 24, 2003, we published a program transmittal in order to manualize the March 5, 2002 Transmittal. (Transmittal 1787, Change Request 2410, dated January 24, 2003). The cover note to the transmittal states, ''Section 15021, Ordering Diagnostic Tests, manualizes Transmittal AB–02–030, dated March 5, 2002. In accordance with negotiated rulemaking for outpatient clinical diagnostic laboratory services, no signature is required for the ordering of such services or for physician pathology services.'' In the manual instructions in that transmittal in a note, we stated: ''No signature is required on orders for clinical diagnostic services paid on the basis of the physician fee schedule or for physician pathology services.'' The manual instructions did not explicitly reference clinical diagnostic laboratory tests as the cover note did. Rather, the transmittal seemed to extend the policy set forth in the **Federal Register** (that no signature is required on requisitions for clinical diagnostic laboratory tests paid under the Clinical Laboratory Fee Schedule) to also apply to clinical diagnostic tests paid on the basis of the PFS and physician pathology services. In addition, the manual instructions used the term ''order'' instead of ''requisition,'' which some members of the industry have asserted caused confusion.

When we transitioned from paper manuals to the current electronic Internet Only Manual system, these manual instructions were inadvertently omitted from the new Benefit Policy Manual (BPM).

In August 2008, we issued a program transmittal (Transmittal 94, Change Request 6100, dated August 29, 2008) to update the BPM to incorporate language that was previously contained in section 15021 of the Medicare Carriers Manual. The reissued language states, ''No signature is required on orders for clinical diagnostic tests paid on the basis of the clinical laboratory fee schedule, the physician fee schedule, or for physician pathology services.'' Based on further review, we have determined that there are no clinical laboratory tests paid under the PFS. After Transmittal 94 was published, we received numerous inquiries from laboratory, diagnostic testing, and hospital representatives who had questions about whether the provision applied to all diagnostic services, including x-rays, MRIs, and other nonclinical laboratory fee schedule diagnostic services.

To resolve any existing confusion surrounding the implementation of the policy in 2001 and subsequent transmittals, we are restating and seeking public comments on our policy. We may further clarify our policy in the final rule, taking into consideration public comments. Our policy is that a physician's signature is not required on a requisition for clinical diagnostic laboratory tests paid on the basis of the Clinical Laboratory Fee Schedule; however, it must be evident, in accordance with our regulations at § 410.32(d)(2) and (3), that the physician ordered the services. The policy that signatures are not required on requisitions applies to requisitions for clinical diagnostic laboratory tests paid under the Clinical Laboratory Fee Schedule.

We note that we solicited and received comments on this signature requirement during the notice and comment period for the March 10, 2000 proposed rule in the context of our proposal to add paragraph (d)(2)(i) to § 410.32 to require that the practitioner who orders a diagnostic laboratory test

must maintain documentation of medical necessity in the beneficiary's medical record. The majority of comments supported the adoption of a policy that the signature of the practitioner on a requisition for a clinical diagnostic laboratory test paid under the Clinical Laboratory Fee Schedule is not the only way of documenting that the test has been ordered and, thus, should not be required provided such documentation exists in an alternate form.

This policy regarding requisitions for clinical diagnostic laboratory tests does not supersede other applicable Medicare requirements (such as those related to hospital Conditions of Participation (CoPs)) which require the medical record to include an order signed by the physician who is treating the beneficiary. Nor do we believe that anything in our policy regarding signatures on requisitions for clinical diagnostic lab tests supersedes other requirements mandated by professional standards of practice or obligations regarding orders and medical records promulgated by Medicare, the Joint Commission, or State law; nor do we believe the policy would require providers to change their business practices. Because of the confusion surrounding the implementation of the policy in 2001 and subsequent transmittals, we invite the general public to comment on this policy and its impacts on operations.

We also are restating and seeking public comment on our long-standing policy consistent with the principle in § 410.32(a) that a written order for diagnostic tests including those paid under the clinical laboratory fee schedule and those that are not paid under the clinical laboratory fee schedule (for example, that are paid under the PFS or under the OPPS), such as X-rays, MRIs, and the TC of physician pathology services, must be signed by the ordering physician or NPP. That is, the policy that signatures are not required on requisitions for clinical diagnostic laboratory tests paid based on the Clinical Laboratory Fee Schedule applies only to requisitions (as opposed to written orders).'' While there may be additional questions about the policy for physician pathology servicess, we are not addressing these issues in rulemaking at this time.

Additionally, we welcome comments from the public about the distinction between an order and a requisition. We note that an ''order'' as defined in our IOM, 100–02, Chapter 15, Section 80.6.1 is a communication from the treating physician/practitioner requesting that a diagnostic test be performed for a beneficiary. The order may conditionally request an additional diagnostic test for a particular beneficiary if the result of the initial diagnostic test ordered yields to a certain value determined by the treating physician/practitioner (for example, if test X is negative, then perform test Y). An order may be delivered via the following forms of communication:

- A written document signed by the treating physician/practitioner, which is hand-delivered, mailed, or faxed to the testing facility.
- A telephone call by the treating physician/practitioner or his or her office to the testing facility; or
- An electronic mail, or other electronic means, by the treating physician/practitioner or his or her office to the testing facility.

If the order is communicated via telephone, both the treating physician/practitioner, or his or her office, and the testing facility must document the telephone call in their respective copies of the beneficiary's medical records.

A ''requisition'', conversely, as we understand it, is the actual paperwork, such as a form, which is provided to a clinical diagnostic laboratory that identifies the test or tests to be performed for a patient. It may contain patient information, ordering physician information, referring institution information, information about where to send reports, billing information, specimen information, shipping addresses for specimens or tissue samples, and checkboxes for test selection. We believe it is ministerial in nature, assisting labs with billing and handling of results, and serves as an administrative convenience to providers and patients. We believe that a written order, which may be part of the medical record, and the requisition are two different documents; although a requisition that is signed may serve as an order. We welcome comments from the public about the distinction between requisitions and orders.

N. Physician Self-Referral

1. General Background

Section 1877 of the Act, also known as the physician self-referral law, prohibits the following: (1) A physician from making referrals for certain designated health services (''DHS'') payable by Medicare to an entity with which he or she (or an immediate family member) has a direct or indirect financial relationship (an ownership/investment interest or a compensation arrangement), unless an exception applies; and (2) The entity from presenting or causing a claim to be presented to Medicare (or billing another individual, entity, or third party payor) for those referred services. The statute establishes a number of exceptions and grants the Secretary the authority to create regulatory exceptions for financial relationships that pose no risk of program or patient abuse.

Determining whether an entity furnishing DHS and a physician have a direct or indirect compensation arrangement is a key step in applying the statute because it affects which compensation exceptions may apply to the arrangement. Section 411.354(c) governs when a physician ''stands in the shoes'' of his or her physician organization and may therefore, depending on the circumstances, have a direct, rather than an indirect, compensation arrangement with an entity furnishing DHS.

Our proposal seeks to clarify one aspect of the physician stand in the shoes provisions at § 411.354(c). Specifically, we are proposing to clarify the second sentence of § 411.354(c)(3)(i) to provide that, ''[w]hen applying the exceptions in § 411.355 and § 411.357 to arrangements in which a physician stands in the shoes of his or her physician organization, the relevant referrals and other business generated ''between the parties' are referrals and other business generated between the entity furnishing DHS and the physician organization (including all members, employees, and independent contractor physicians).'' A detailed discussion of this proposed clarification may be found in section II.N.2.b. of this proposed rule.

2. Physician Stand in the Shoes

a. Background

One of the first significant physician stand in the shoes provisions was finalized in the ''Medicare Program; Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships (Phase II),'' interim final rule with comment period published in the March 26, 2004 **Federal Register** (69 FR 16054) (''Phase II''). In Phase II, we revised the definition of ''referring physician'' at § 411.351 to clarify that a referring physician is treated as ''standing in the shoes'' of his or her professional corporation (69 FR 16058, 16060). Our revision to the definition of ''referring physician'' clarified that it was not necessary to treat a referring physician as separate from his or her wholly-owned professional corporation. We noted that the revised regulations should make it simpler for physicians and others to evaluate their financial relationships and to apply exceptions

under section 1877 of the Act. We also solicited comments on whether to permit a physician to stand in the shoes of a group practice of which he or she is a member (69 FR 16060).

We addressed certain provisions of section 1877 of the Act, including provisions relating to direct and indirect compensation arrangements, in the ''Medicare Program; Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships (Phase III),'' final rule published in the September 5, 2007 **Federal Register** (72 FR 51012) (''Phase III''). Phase III extended the Phase II rule that treated referring physicians as standing in the shoes of their wholly-owned professional corporations only (72 FR 51026). Specifically, we amended § 411.354(c) to add a provision under which all referring physicians will be treated as ''standing in the shoes'' of their physician organizations for purposes of applying the rules that describe direct and indirect compensation arrangements in § 411.354 (72 FR 51026 through 51029). Phase III defined a ''physician organization'' at § 411.351 to be ''a physician (including a professional corporation of which the physician is the sole owner), a physician practice, or a group practice that complies with the requirements of § 411.352.'' Under Phase III, when determining whether a direct or indirect compensation arrangement existed between a physician and an entity to which the physician refers Medicare patients for DHS, the referring physician would stand in the shoes of: (1) Another physician who employs the referring physician; (2) his or her wholly-owned professional corporation; (3) a physician practice (that is, a medical practice) that employs or contracts with the referring physician; or (4) a group practice of which the referring physician is a member or independent contractor. We specified in § 411.354(c)(3)(i) that a physician who stands in the shoes of his or her physician organization would be considered to have the same compensation arrangements (with the same parties and on the same terms) as the physician organization in whose shoes the referring physician stands. In addition, we specified in the second sentence of § 411.354(c)(3)(i) that ''[f]or purposes of applying the exceptions in § 411.355 and § 411.357 to arrangements in which a physician stands in the shoes of his or her physician organization, the 'parties' to the arrangements are considered to be the entity furnishing DHS and the physician organization (including all members, employees, or independent contractor physicians).''

The Phase III stand in the shoes rules were made in an effort to address two issues. First, industry representatives had asserted that resorting to the indirect compensation definition and exception added an unnecessary step when determining compliance with the physician self-referral prohibition. These representatives believed that it would be easier, more efficient, and consistent with the intent of the physician self-referral law to examine the relationship between the hospital and the group practice for compliance with a physician self-referral exception. The representatives urged that a referring physician should stand in the shoes of his or her group practice, which acts on behalf of its physician members and contractors. Depending on the circumstances, this would enable the parties to analyze the arrangement between the entity furnishing DHS and the group practice (for example, a lease of office space, a personal service arrangement, or a fair market value compensation arrangement) to determine its compliance with one of the various direct compensation arrangement exceptions, rather than the indirect compensation arrangements exception at § 411.357(p). We agreed and permitted a physician to stand in the shoes of his or her group practice, thereby permitting physicians and entities furnishing DHS to use a direct compensation arrangement exception in some circumstances.

Second, we were informed that parties may have construed the definition of an indirect compensation arrangement too narrowly, resulting in erroneous determinations that some arrangements involving financial incentives for referring physicians would fall outside the ambit of the physician self-referral law. In particular, we were concerned that some arrangements between entities furnishing DHS and group practices were viewed as outside the application of the statute. The stand in the shoes provisions set forth in Phase III were designed to address this concern by treating compensation arrangements between entities furnishing DHS and group practices as if the arrangements were with the group's referring physicians.

In response to concerns raised by some industry representatives, we published a final rule in the November 15, 2007 **Federal Register** (72 FR 64161) delaying the date of applicability of the Phase III stand in the shoes provisions with respect to certain compensation arrangements involving physician organizations and academic medical centers or certain integrated 501(c)(3) health care systems, from December 4, 2007 until December 4, 2008.

We finalized revisions to § 411.354(c)(1)(ii) to deem (so as to require) a physician who has an ownership or investment interest in a physician organization to stand in the shoes of that physician organization in the ''Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates; Payments for Graduate Medical Education in Certain Emergency Situations; Changes to Disclosure of Physician Ownership in Hospitals and Physician Self-Referral Rules; Updates to the Long-Term Care Prospective Payment System; Updates to Certain IPPS-Excluded Hospitals; and Collection of Information Regarding Financial Relationships Between Hospitals'' final rule (''FY 2009 IPPS final rule'') published in the August 19, 2008 **Federal Register** (73 FR 48434). Physicians with only a titular ownership interest (that is, physicians without the ability or right to receive the financial benefits of ownership or investment, including, but not limited to, the distribution of profits, dividends, proceeds of sale, or similar returns on investment) are not deemed to stand in the shoes of their physician organizations. We also added § 411.354(c)(1)(iii) to permit (but not require) a titular owner and a physician who does not have an ownership or investment interest in a physician organization to stand in the shoes of his or her physician organization. This rule became effective October 1, 2008.

b. Proposed Clarification to § 411.354(c)—Applying Exceptions in § 411.355 and § 411.357 to Arrangements in Which a Physician Stands in the Shoes of His or Her Physician Organization

Section 411.354(c)(3)(i) addresses the application of the general exceptions to the referral prohibition related to both ownership/investment and compensation (§ 411.355) and the exceptions to the referral prohibition related to compensation arrangements (§ 411.357), to arrangements in which a physician stands in the shoes of his or her physician organization. Many of these exceptions require the arrangement to be in writing and signed by the parties and prohibit the compensation from taking into account the volume or value of referrals or other business generated by the referring physician.

Under § 411.354(c)(3)(i), a physician who stands in the shoes of his or her

physician organization is deemed to have the same compensation arrangements with the same parties and on the same terms as the physician organization. The second sentence of § 411.354(c)(3)(i) provides that ''[f]or purposes of applying the exceptions in § 411.355 and § 411.357 to arrangements in which a physician stands in the shoes of his or her physician organization, the 'parties' to the arrangements are considered to be the entity furnishing DHS and the physician organization (including all members, employees, or independent contractor physicians).''

After the publication of Phase III, some members of the industry questioned whether the second sentence of § 411.354(c)(3)(i) defined the term ''parties'' everywhere it appears in the physician self-referral regulations, including the requirement in many exceptions that a compensation arrangement be in writing and ''signed by the parties.'' Specifically, these members believed it was necessary for everyone within a physician organization (that is, all members, employees, and independent contractor physicians) to sign a myriad of different arrangements with an entity furnishing DHS. This was not our intent. In January 2008, we posted a frequently asked question (FAQ) on our Web site to address this issue (*see* question #8885 at *https://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_adp.php?p_faqid=8885*.) In the FAQ, we explained that a physician who stands in the shoes of his or her physician organization need not become a signatory to a written agreement between the physician organization and an entity furnishing DHS because ''we consider a physician who is standing in the shoes of his or her physician organization to have signed the written agreement when the authorized signatory of the physician organization has signed the agreement.'' After the FY 2009 IPPS final rule, under which only physician owners are deemed to stand in the shoes of their physician organizations, some industry representatives questioned whether physicians who did not stand in the shoes remained ''parties'' under § 411.354(c)(3)(i) and would therefore need to become signatories to any compensation arrangement that was required to be in writing and ''signed by the parties.''

We are proposing to clarify the second sentence of § 411.354(c)(3)(i) to provide that, ''[w]hen applying the exceptions in § 411.355 and § 411.357 to arrangements in which a physician stands in the shoes of his or her physician organization, the relevant referrals and other business generated 'between the parties' are referrals and other business generated between the entity furnishing DHS and the physician organization (including all members, employees, and independent contractor physicians).'' We believe this proposed language clarifies the regulation text and is consistent with our intent to minimize the potential for abuse without imposing undue burden on the provider community.

Our proposed change clarifies that we are not defining the term ''parties'' and should eliminate any possible public misconception that all physicians in a physician organization (whether or not they stand in the shoes of the physician organization) must sign the writing(s) memorializing a compensation arrangement between their physician organization and an entity furnishing DHS. Furthermore, we note that some members of the industry have erroneously applied the second sentence of § 411.354(c)(3)(i) by analyzing whether the compensation takes into account the referrals between the entity furnishing DHS and the physician who stands in the shoes of the physician organization only, not the referrals of all members, employees, and independent contractor physicians in the physician organization. As we indicated in the Phase III final rule (72 FR at 51028), the second sentence of § 411.354(c)(3)(i) was intended to require (where applicable) an analysis of whether a compensation arrangement takes into account referrals or other business generated by the physician organization as a whole and not merely referrals or other business generated by the physicians who stand in its shoes. Thus, we reiterate that the relevant referrals and other business generated between the physician organization and the entity furnishing DHS are the referrals of all physicians in the physician organization (including all members, employees, and independent contractors), not simply the referrals made by each physician who stands in the shoes of the physician organization.

We welcome public comments regarding alternative approaches to address this issue.

O. Durable Medical Equipment-Related Issues

1. Damages to Suppliers Awarded a Contract under the Acquisition of Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (Medicare DMEPOS Competitive Bidding Program) Caused by the Delay of the Program

Section 1847 of the Act, as amended by section 302(b)(1) of the MMA, requires the Secretary to establish and implement a Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Program (DMEPOS CBP). On July 15, 2008, the MIPPA was enacted. Section 154 of the MIPPA amended section 1847 of the Act to make certain limited changes to the competitive bidding program, including adding a new subsection (a)(1)(D) to section 1847 of the Act. Section 1847(a)(1)(D) terminates retroactively the competitive bidding contracts that were awarded to suppliers in 2008 for the Round 1 of competitive bidding and prohibits payment based on such contracts. Section 154 of the MIPPA effectively reinstated payment for competitively bid items and services to the Medicare fee schedule amounts, as set forth in section 1834 of the Act and 42 CFR part 414, subpart D of our regulations.

Section 1847(a)(1)(D)(i)(I) of the Act, as amended by the MIPPA, stipulates that to the extent any damages may be applicable as a result of the termination of contracts, payment is to be made from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Act. Section 1847(a)(1)(D) of the Act also states that nothing in section 1847(a)(1)(D)(i)(I) of the Act, which includes the reference to damages, shall be construed to provide an independent cause of action or right to administrative or judicial review with the regard to the termination of the Round 1 contracts.

For further discussion of the Competitive Bidding Program and the bid evaluation process, see the Medicare Program; Competitive Acquisition for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) and Other Issues final rule published in the April 10, 2007 **Federal Register** (72 FR 17992) and the Medicare Program; Changes to the Competitive Acquisition of Certain Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) by Certain Provisions of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) interim final rule with comment period (IFC)

published on January 16, 2009 **Federal Register** (74 FR 2873).

In this proposed rule, we are proposing to add new § 414.425 to establish a process to evaluate any claims for damages caused by the termination of contracts awarded in 2008 under the DMEPOS CBP that were terminated as a result of section 154(a)(1)(A)(iv) of the MIPPA.

We offered contracts in March of 2008 to selected suppliers for the first round of the DMEPOS CBP. The contracts that were accepted were terminated by the MIPPA retroactive to June 30, 2008. We considered the terms of the contracts and other processes of the DMEPOS CBP as we developed this proposed process to determine, on a case-by-case basis, whether to award damages and, where applicable, the amount of damages to be awarded for the termination of these contracts.

When considering whether to submit a claim for damages, suppliers may consider the following factors:

- Each contract stipulated that the contract is subject to any changes to the statute or regulations that affect the Medicare program.
- Each contract indicated CMS does not guarantee any amount of business or profits.
- Each contract stipulated that CMS shall not pay for any expenses incurred by the supplier for the work performed under the contract other than for payment of Medicare claims authorized under the contract.
- Upon termination of the contracts by the MIPPA, payments reverted to the CY 2008 fee schedule amount, which was on average 26 percent higher than payment amounts under the DMEPOS CBP.
- We will review a supplier's estimated and historic capacity and any expansion plans that were submitted as part of a supplier's bid.
- We will review a supplier's action to meet its obligation to mitigate its damages.
- We listed the winning suppliers on the Medicare.gov Web site in the supplier locator tool; a supplier is allowed to keep any new customers they may have obtained because of being listed on the supplier locator tool.
- This list is not intended to suggest that there are not legitimate claims for damages. However, these are factors that a supplier may consider when deciding whether to submit a claim for damages.

The provisions of this proposed rule outline the information that we are proposing suppliers provide when submitting claims for damages and the process that we will follow to review these claims. The information we propose to collect from suppliers is necessary for us to make a reasonable decision on whether damages are warranted and how much in damages should be awarded. We believe the process is not overly burdensome to those suppliers choosing to participate in this review process and will ensure a thorough review of a supplier's claim for damages.

The proposed process to file a claim for damage claims includes the following provisions:

a. Eligibility To File a Claim

Any aggrieved supplier that was awarded a contract in 2008 for the Round 1 DMEPOS CBP and believes it has suffered damages is eligible to submit a claim. The supplier must be able to demonstrate how its company was damaged. These damages must be substantiated and be as a direct result of the termination by MIPPA of their Round I DMEPOS CBP contract. Only a contract supplier, and not a subcontractor of a contract supplier, is eligible to submit a claim for damages.

b. Timeframes for Filing a Claim

A completed claim, including all documentation described below in section II.O.1.c., must be filed within 90 days of the effective date of the finalization of these damages provisions, unless the 90th day is a weekend or Federal holiday. In that case, the last date to file a claim will be the day following the weekend or Federal holiday. The date of filing is the actual date of receipt by the CBIC of a completed claim from the supplier that includes all of the information required by this rule. We strongly urge claimants to use a tracking method such as with the United States Postal Service or a carrier that requires a return receipt that indicates the date on which the claim was delivered.

c. Information That Must Be Included in a Claim

At a minimum, a claim should include all of the following:

- Supplier's name and bidding number.
- Supplier's current contact information (Name of authorized official, U.S. Post Office mailing address, phone number and e-mail address).
- A copy of the DMEPOS CBP Round I contract(s) the supplier signed with CMS.
- A detailed explanation of the damages incurred by the supplier. The explanation must document the supplier's damages through receipts and records that establish the claimant's damages directly related to meeting the terms of the DMEPOS CBP Round I contract.
- The supplier must also explain how it would be damaged if not reimbursed.
- A detailed explanation of the steps of all attempts to use for other purposes, return, or dispose of equipment or other assets purchased or rented for use in the Round I DMEPOS CBP contract performance.

Damages claimed must be specifically related to carrying out the terms of the contract, and may include, but are not limited to, the following:

- Items or equipment purchased or rented.
- Additional employee costs.
- Additional inventory costs.
- Additional facility costs.

The supplier must include a separate justification for any of these items for which it is claiming damages and explain how they were necessary in terms of meeting the requirements of the Round 1 DMEPOS CBP contract. This does not include expenses that would have occurred if the supplier had not been awarded a contract but only those expenses that were incurred for the Round 1 DMEPOS CBP contract performance. The claim must also detail steps taken by the supplier to mitigate damages that they may have incurred due to the contract termination.

d. Items That Will Not Be Considered in a Claim

CMS will not award damages for the following:

- Cost of submitting a bid.
- Cost of preparing or submitting a claim for damages under this section.
- Fees or costs incurred for consulting or marketing.
- Cost of accreditation or licensure.
- Costs incurred before March 20, 2008.
- Costs incurred after July 14, 2008 except for costs incurred to mitigate damages.
- Any profits a supplier may have expected from performance of the contract.
- Costs that would have occurred without the supplier having been awarded a contract.
- Costs for items such as inventory, delivery vehicles, office space and equipment, personnel, which the supplier did not purchase specifically to perform the contract.
- Costs already recouped by use of personnel, material, supplies, or equipment in the supplier's business operations.

We are not considering claims for expenses incurred prior to March 20, 2008 including the purchase or rental of

items or equipment before that date, because a supplier would not have known that it was going to be offered a contract. We are not considering claims for most expenses incurred after July 14, 2008, including the purchase or rental of items or equipment, because this is the date on which MIPPA terminated all of the Round 1 contracts.

e. Filing a Claim

Suppliers should submit claims, with all supporting documentation, with the CMS Competitive Bidding Implementation Contractor (CBIC) at the following address: CBIC; Bldg 200, Suite 400; 2743 Perimeter Parkway; Augusta, Georgia 30909. The authorized official for the supplier must certify the accuracy of the information on the claim and all supporting documentation. The authorized official is appointed by the supplier and has the legal authority granted by the supplier to submit the claim for damages. This person may be the supplier's general partner, chairman of the board, chief financial officer, chief executive officer, president, direct owner of the supplier organization, or must hold a position of similar status and authority within the supplier's organization. The CBIC will not accept electronic submissions of claims for damages.

f. Review of Claim

(1) Role of the CBIC

The CBIC will conduct the first level of review and make recommendations to CMS, hereafter referred to as the Determining Authority regarding:

- Whether the claim is complete and was filed in a timely manner. The CBIC may seek further information from the claimant when making its recommendation. The CBIC may set a deadline for receipt of additional information.

- When the claim is incomplete or was not filed in a timely manner, the CBIC will make a recommendation to the Determining Authority not to process the claim further.

- Whether the government owes damages because of the MIPPA. The CBIC will include an explanation supporting its recommendation. The CBIC will recommend a reasonable amount of damages, if any, based on the claim submitted, including all accompanying documentation. The CBIC will consider the language of the contract, as well as both costs incurred and the contract supplier's attempts and actions to limit the damages.

(2) CMS' Role as the Determining Authority

CMS is the Determining Authority because we are responsible for the final review and final determination regarding claims for damages.

- The Determining Authority shall review the recommendation of the CBIC.

- The Determining Authority may seek further information from the claimant or the CBIC in making a concurrence or non-concurrence determination.

- The Determining Authority may set a deadline for receipt of additional information. A claimant's failure to respond timely may result in a denial of the claim.

- If the Determining Authority concurs with the CBIC recommendation, the Determining Authority shall submit a final signed decision to the CBIC and direct the CBIC to notify the claimant of the determination and the reasons for the final determination.

- If the Determining Authority nonconcurs with the CBIC recommendation, the Determining Authority may:

+ Write a determination granting (in whole or in part) a claim for damages or denying a claim in its entirety; or direct the CBIC to write said determination for the Determining Authority's signature.

+ Return the claim to the CBIC with further instructions.

- The Determining Authority's determination is final and binding; it is not subject to administrative or judicial review under section 1847(a)(1)(D) of the Act, as amended by section 154(a)(1) of the MIPPA.

g. Timeframe for Final Determinations

Every effort will be made to make a final determination within 120 days of initial receipt of the claim for damages by the CBIC or the receipt of additional information that was requested by the CBIC, whichever is later. In the case of more complex cases, or in the event of a large workload, a decision will be issued as soon as practicable.

h. Notification to Claimant of Damage Determination

The CBIC shall mail the final determination to the claimant by certified mail return receipt requested. If CMS determines that money is due to a claimant, this notification will indicate when and how the money will be transmitted. If a monetary award is due, the supplier will be required to provide banking information for electronic deposit.

2. Notification to Beneficiaries for Suppliers Regarding Grandfathering

Section 1847(a)(4) of the Act requires that in the case of covered durable medical equipment (DME) items for which payment is made on a rental basis under section 1834(a) of the Act, and in the case of oxygen for which payment is made under section 1834(a)(5) of the Act, the Secretary shall establish a ''grandfathering'' process under which rented DME items that were furnished prior to the start of the Competitive Bidding Program (CBP) may be continued to be rented to the beneficiary by a noncontract supplier. Agreements for those covered items and supplies that were rented by the supplier to the beneficiary before the start of a CBP may be continued, regardless of whether the existing supplier participates in the CBP.

In the April 10, 2007 final rule (72 FR 17992), in § 414.408(j), we established the grandfathering process described below for rented DME and oxygen and oxygen equipment when these items are included under the Medicare DMEPOS CBP. A supplier that is furnishing DME or is furnishing oxygen or oxygen equipment on a rental basis to a beneficiary prior to the implementation of a CBP in the competitive bidding area (CBA) where the beneficiary maintains a permanent residence may elect to continue furnishing the item as a grandfathered supplier. This process only applies to suppliers that began furnishing the competitive bid items described above before the start of the CBP to beneficiaries who maintain a permanent residence in a CBA.

In the case of the rented DME and oxygen and oxygen equipment identified in this section, we established in § 414.408(j)(4) that Medicare beneficiaries have the choice of deciding whether they would like to continue receiving the rented item from a grandfathered supplier or if they would like to receive the item from a contract supplier.

Suppliers that agree to be a grandfathered supplier for an item must agree to be a grandfathered supplier for all current beneficiaries who request to continue to rent that item from them. The beneficiary's decision to use a grandfathered supplier depends on the decision of the noncontract supplier that is currently renting the competitive bidding item to continue renting the item as a grandfathered supplier after the start of the CBP in accordance with the terms we have specified. The payment rules for grandfathered suppliers are specified in existing § 414.408(j)(2).

In addition, the beneficiary may elect, at any time, to transition from a noncontract supplier to a contract supplier. The contract supplier would be required to accept the beneficiary as a customer regardless of how many rental months had already been paid for the beneficiary to receive this item. If the grandfathered supplier is not willing to continue furnishing the item, a beneficiary must select a contract supplier to furnish the item in order to receive Medicare payment for that item. The grandfathered supplier is paid based on the payment rules outlined in the final rule on Competitive Bidding at § 414.408(j).

As a result of what we learned from Round 1 of the CBP, we are proposing changes to the ''grandfathering'' rules by establishing notification requirements for noncontract suppliers that are furnishing rented DME competitive bid items at the time a CBP begins to beneficiaries residing in a CBA. We are also proposing a new definition for a grandfathered item to include all rented item(s) in a competitive bidding product category that a supplier currently provides to its beneficiaries. Under the current regulation, suppliers may choose the items within a product category for which they want to become a grandfathered supplier. Under this proposed rule, a noncontract supplier would have to choose to be either a grandfathered supplier for all or for none of the rented DME items within a product category that the supplier currently provides.

For further discussion of the CBP and the bid evaluation process, *see* the April 10, 2007 final rule and the January 16, 2009 interim final rule with comment period.

We are proposing to revise the definition of ''grandfathered item'' in § 414.402 so that the term would refer to all rented items within a competitive bid product category that the supplier currently rents to beneficiaries. In addition, we are proposing to redesignate the current § 414.408(j)(5) as § 414.408(j)(7) and add new § 414.408(j)(5)and (j)(6). The new § 414.408(j)(5)and (j)(6) will specify the notification requirements that apply to noncontract suppliers that are renting DME competitive bid items in a CBA at the time of implementation of the CBP.

a. Definition of a Grandfathered Item

We are proposing to revise the definition of a ''grandfathered item'' in § 414.402 to avoid confusion, on the part of beneficiaries, regarding rented DME items for which a noncontract supplier is willing or not willing to be a grandfathered supplier. Under the current regulations, a supplier may make separate choices regarding grandfathering for each individual HCPCS code. For example, a supplier may choose to be a grandfathered supplier for a particular type of walker within the product category instead of all of the walkers included in that product category that are furnished on rental basis.

Under the revised definition, a noncontract supplier would have to choose to be either a grandfathered supplier for all or for none of the DME rented items within a product category that the supplier currently provides. We believe that it would be easier for beneficiaries to recognize which items a supplier is grandfathering or not grandfathering if the supplier's election concerning grandfathering was made by product category rather than making separate choices for each individual HCPCS code. In addition, this proposed revision would prevent suppliers from choosing to be a grandfathered supplier for only the more profitable items, which could disadvantage certain beneficiaries.

b. Notification of Beneficiaries and CMS by Suppliers That Choose To Become Grandfathered Suppliers

We are proposing to add a new § 414.408(j)(5) to require suppliers furnishing items to be included in a CBP that are eligible for grandfathering to notify beneficiaries in the CBA and CMS regarding their decision whether to become grandfathered suppliers.

The notification requirements we are proposing will prohibit certain inappropriate practices of noncontract suppliers. These inappropriate practices include: (1) Suppliers attempting to receive additional monthly rental payments from Medicare by circumventing the grandfathering requirements; and (2) suppliers not formally notifying beneficiaries before picking up the rented item from the beneficiary's home. We are also proposing to require a notification process to protect beneficiaries and to ensure less confusion during the transition period prior to implementation of the CBP. The proposed requirements will help ensure that beneficiaries are contacted and informed about the grandfathering process and what choices they have concerning their choice of supplier. Moreover, the notice will help to ensure that beneficiaries do not have medically necessary DME equipment taken from them unexpectedly by a noncontract supplier.

(1) Notification of Beneficiaries by Suppliers That Choose to Become Grandfathered Suppliers

We are proposing to add § 414.408(j)(5)(i) which requires a noncontract supplier that elects to become a grandfathered supplier in a CBA to provide a written notification to each Medicare beneficiary in that CBA who is currently renting a grandfathered item from that supplier. The notification must state that the supplier is willing to continue to rent the grandfathered item(s) to the beneficiary as a grandfathered supplier. The notice must identify the DME grandfathered rented items for which the supplier will be a grandfathered supplier.

To ensure that beneficiaries are sufficiently informed and prepared for competitive bidding changes that affect rented DME, we are proposing in § 414.408(j)(5) to require that the notification of the beneficiary must meet the following requirements. The notification must:

- Be sent by the supplier to the beneficiary at least 30 business days before the start date of the implementation of the CBP in the CBA in which the beneficiary resides. The 30-day notice is necessary to give the beneficiary sufficient time before the start of the CBP to consider whether to continue to use their current supplier. Suppliers will be given sufficient time to meet the 30-day notification requirement.
- Identify the grandfathered items that the supplier is willing to continue to rent to the beneficiary.
- Be in writing (for example, by letter or postcard) and the supplier must maintain proof of delivery.
- State that the supplier is offering to continue to furnish certain rented DME, oxygen and oxygen equipment, and supplies that the supplier is currently furnishing to the beneficiary (that is, before the start of the CBP) and is willing to continue to provide these items to the beneficiary for the remaining rental months.
- State that the beneficiary has the choice to continue to receive a grandfathered item(s) from the grandfathered supplier or may elect to receive the item(s) from a contract supplier after the end of the last month for which a rental payment is made to the noncontract supplier.
- Provide the supplier's telephone number and instruct the beneficiaries to call the supplier with questions regarding grandfathering and to notify the supplier of his or her election.
- State that the beneficiary can obtain information about the CBP by calling

1–800–MEDICARE or accessing *http://www.medicare.gov* on the Internet.

In § 414.408(j)(i)(B), we propose that the supplier should obtain an election from the beneficiary and maintain a record of its attempts to communicate with the beneficiary to obtain the beneficiary's election regarding grandfathering. We are also proposing that the supplier maintain a record of the beneficiary's choice, the date on which the choice was made, and how the beneficiary communicated his or her choice to the supplier. The 30-day notice to the beneficiary must be in writing to ensure that there is a record that the notification was made.

We are proposing to add paragraphs § 414.408(j)(5)(i)(C)(*1*) through (*3*) which state if the beneficiary chooses not to continue to receive a grandfathered item(s) from the noncontract supplier, the supplier must provide the beneficiary with 2 additional notices prior to picking up its equipment. These notices are described below as the 10-Day Notification and the 2-Day Notification.

(i) 10-Day Notification

Ten business days prior to picking up the item, the supplier should have direct contact (for example, a phone call) with the beneficiary or the beneficiary's caregiver and receive acknowledgement that the beneficiary understands their equipment will be picked up and that this should occur on the first anniversary date after the start of the CBP or another date agreed to by the beneficiary. The noncontract supplier must bill and will be paid for the furnishing of the equipment up to the first anniversary date after the start of the CBP and the new supplier cannot bill for furnishing the equipment prior to this anniversary date. This requirement still applies if a date other than the anniversary date is chosen.

The beneficiary's anniversary date occurs every month on the date of the month on which the item was first delivered to the beneficiary by the current supplier. The anniversary date marks the date of every month on which a new monthly rental period begins. For example, using July 1 as the beginning date of the Medicare DMEPOS CBP:

- If a beneficiary's last anniversary date before the beginning of the CBP is June 29, the noncontract supplier must submit a claim for the rental month beginning June 29 and ending July 28. The noncontract supplier should not pick up the equipment prior to July 29. In this case, the noncontract supplier has been paid up to July 29 and therefore should pick up its equipment on July 29, and the contract supplier would deliver its equipment on July 29 and begin billing for the next month's rental as of that date.
- If a beneficiary's anniversary date is July 1, also the beginning date for the CBP, the noncontract supplier should not pick up the equipment before July 1 and should not submit a claim for the July rental period. The contract supplier should deliver the equipment to the beneficiary on July 1 and submit a claim for this month.

When a DME supplier submits a monthly bill for capped rental DME items, the date of delivery (''from'' date) on the first claim must be the ''from'' or anniversary date on all subsequent claims for the item. For example, if the first claim for a wheelchair is dated September 15, all subsequent bills must be dated for the 15th of the following months (October 15, November 15, *etc.*). In cases where the anniversary date falls at the end of the month (for example, January 31) and a subsequent month does not have a day with the same date (for example, February), the final date in the calendar month (for example, February 28) will be used.

(ii) 2-Day Notification

Two business days prior to picking up the item, the supplier must contact the beneficiary by phone to remind the beneficiary of the date the supplier will pick up the item. This supplier should not pick up the item before the beneficiary's first anniversary date that occurs after the start of the CBP.

There may be unusual circumstances that make it difficult to contact certain beneficiaries. However, we do not expect this to occur often because these suppliers have been submitting monthly rental claims for providing services to these beneficiaries. Therefore, the supplier should have an ongoing relationship with the beneficiary and be aware of how to contact them and any changes in their circumstances. However, under no circumstance should a supplier pick up a rented item prior to the supplier's receiving acknowledgement from the beneficiary that they are aware of the date on which the supplier is picking up the item and that arrangements have been made to have the item replaced on that date by a contract supplier. The pickup of the noncontract supplier's equipment and the delivery of the new contract supplier's equipment should occur on the same date. The pick up by the noncontract supplier and the delivery by the contract supplier should occur on the first rental anniversary date of the equipment that occurs after the start of the CBP. When a beneficiary chooses to switch to a new contract supplier, the current noncontract supplier and the new contract supplier must make arrangements that are suitable to the beneficiary. This provides some latitude, for the pickup and the delivery date but not in terms of billing. The new equipment cannot be billed for until the anniversary date and the old equipment cannot be taken from the beneficiary before the anniversary date.

c. Notification to CMS for Suppliers That Choose To Become Grandfathered

We are proposing to add § 414.408(j)(5)(ii) to state that suppliers that have chosen to become grandfathered suppliers must also notify CMS of that decision at least 30 business days before the start of the CBP. We believe that 30 business days is a reasonable period to allow us to compile a list of grandfathered suppliers and to answer questions about the availability of these suppliers. Unless the supplier notifies CMS consistent with this subsection, the supplier will not be considered a grandfathered supplier. Having a list of grandfathered suppliers is important to assist CMS in administering the grandfathering process. The list will be used to answer questions from beneficiaries concerning which suppliers have chosen the grandfathering option. The notification requirement will also help us to ensure that suppliers are not offering the grandfathering option to only a select number of beneficiaries. Also, having a list of suppliers that have chosen to be grandfathered suppliers will assist us in reviewing whether only noncontract suppliers that have elected to be grandfathered suppliers have received Medicare payment for rented competitive bid items in a CBA.

The notice that a noncontract supplier must provide to CMS if it elects to become a grandfathered supplier must meet the following requirements:

- State that the supplier agrees to continue to furnish certain rented DME, oxygen and oxygen equipment that it is currently furnishing to beneficiaries (that is, before the start of the CBP) in a CBA and will continue to provide these grandfathered items to these beneficiaries for the remaining months of the rental period.
- Include all of the following: Name and address of the supplier; 6-digit NSC number of the supplier; and product category(s) by CBA for which the supplier is willing to be a grandfathered supplier.
- Suppliers with multiple locations must submit one notification for the company rather than for each individual location.

• State that the supplier agrees to meet all the terms and conditions applicable to grandfathered suppliers.

• Be provided by the supplier to CMS in writing at least 30 business days before the start date of the implementation of a CBP.

d. Notifications of Beneficiaries by Suppliers That Choose Not To Become Grandfathered Suppliers

We propose to clarify under § 414.408(j)(6) that a noncontract supplier that elects not to become a grandfathered supplier is required to pick up the item it is currently renting to the beneficiary from the beneficiary's home after proper notice to the beneficiary. A noncontract supplier that decides not to become a grandfathered supplier does not have the option of leaving its equipment in the beneficiary's home. The noncontract supplier is responsible for picking up the item from the beneficiary.

Proper notification by a supplier who chooses not to become a grandfathered supplier must include a 30-day, a 10-day, and a 2-day notice of its decision not to be a grandfathered supplier. These notifications must meet all of the requirements listed above for the 30-day, 10-day and 2-day notices that must be sent by suppliers who decide to be grandfathered suppliers, except for the following differences for the 30-day notice.

• The 30-day notice must indicate the items for which the supplier has decided not to become a grandfathered supplier and indicate the date upon which the equipment will be picked up.

• It must state that the supplier will only continue to rent these competitively bid item(s) up to the beneficiary's first anniversary date, as defined in § 414.408(j)(5), that occurs after the start of the Medicare DMEPOS CBP.

• It must also state that the beneficiary must select a contract supplier for Medicare to continue to pay for these items.

• It must state that the beneficiary can obtain information about the CBP by calling 1–800–MEDICARE or accessing *http://www.medicare.gov* on the Internet.

• It must also refer him or her to the supplier locator tool on *http://www.medicare.gov*.

The supplier must also provide the beneficiary with the 10-day and the 2-day notices prior to picking up their equipment.

When a beneficiary chooses to switch to a new contract supplier, the current noncontract supplier and the new contract supplier must make arrangements that are suitable to the beneficiary. This provides some latitude, but the new equipment may not be billed by the contract supplier until the first anniversary date following the start of the CBP. Also, the old equipment may not be taken from the beneficiary before proper arrangements are made and the date of service cannot occur before the anniversary date.

As discussed above, under no circumstance should a supplier pick up the rented item prior to the supplier making an arrangement with the new contract supplier for the delivery of the new equipment at a time suitable to meet the beneficiary's medical needs. The noncontract supplier has been furnishing services to the beneficiary and receiving payments from the program. To ensure that the beneficiary has continued access to medically necessary equipment, the noncontract supplier is expected to assist the beneficiary in locating a contract supplier. The noncontract supplier should communicate with the beneficiary the urgency of arranging to have the new equipment delivered as soon as possible.

P. Physician Fee Schedule Update for CY 2010

Since 1999, PFS rates have been updated under the sustainable growth rate (SGR) system. The general concept under the SGR system is that growth in total expenditures for physicians' services should be limited to sustainable levels. If expenditures exceed a statutorily determined percentage increase amount, the PFS update for the following year is reduced. If expenditures are less than the percentage increase amount, the PFS update is increased in the following year. There is a recognized tendency for physicians to increase the volume and intensity of their services over time. Incentives under SGR system were intended to encourage physicians to regulate their collective behavior in that regard in order to avoid decreases in future updates. The SGR is also a cumulative system. The update is adjusted based on a comparison of cumulative actual spending to target spending from a base period through the current year. Thus, if spending exceeds the target in a single year, the following year's update must be adjusted to reduce annual expenditures, as well as recoup the difference between target and actual spending in the prior year. Under a cumulative system, deviations between target and actual spending have the potential to result in significantly more payment rate adjustments when actual spending exceeds target spending even in a single year.[20] Further, under a cumulative system, past increases in spending levels above the target will continue to affect future PFS updates until there have been sufficient adjustments to make target and actual spending equal.

Despite the intended incentives, actual spending under the SGR system has deviated significantly from target spending. In the CY 2004 PFS final rule with comment period (68 FR 63248), we estimated CY 2003 allowed expenditures at $71.7 billion and CY 2003 actual expenditures at $77.8 billion for a difference of $6.1 billion (or 8.5 percent of allowed spending). The cumulative difference between target and actual expenditures estimated at the time was $7.8 billion (that is, the $6.1 billion plus an additional $1.7 billion for past differences between target and actual spending since the 1996/1997 base year not previously accounted for through adjustments to the PFS update). Under the statutory formula, CMS was required to announce a reduction in PFS rates of 4.5 percent for CY 2004:

> [T]he negative physician fee schedule update gives us no alternative to reducing physician fee schedule rates. Only Congress can change the law and avert a reduction in 2004 physician fee schedule rates. (68 FR 63239)

On November 25, 2003, the Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173). The President signed the MMA into law on December 8, 2003. Section 601 of MMA amended section 1848(d) of the Act to specify that the update to the single conversion factor (CF) for CYs 2004 and 2005 shall not be less than 1.5 percent. Thus, instead of applying an update of −4.5 percent in 2004, we applied an increase of 1.5 percent to PFS rates. The Congress took similar actions to avert reductions to PFS rates for CYs 2006 through 2009. Because the legislation did not affect the computation of the levels of allowed and actual expenditures for these years, there is now a substantial difference between cumulative target and actual spending that must be accounted for through future reductions to PFS rates. In a March 1, 2009 letter from CMS to the MedPAC, we estimated the difference between cumulative target and actual spending from the 1996/1997 base year through December 2009 at $69.7 billion. We estimated the PFS update would be

[20] The adjustments to equate allowed and actual spending do not occur in a single year. The Balanced Budget Refinement Act of 1999 specifies a formula that makes the adjustment to account for differences between target and actual spending over multiple years.

−21.5 percent for CY 2010. As there are limits to how much PFS rates can be reduced in a single year and the estimated −21.5 percent PFS update will not fully account for the difference between target and actual spending, we are estimating further reductions of between 5 and 6.5 percent for the next several years.

Although the Congress has acted to avert reductions in the past several years, these projections have led us to reexamine administrative actions that the Secretary could take to lessen the potential for repeated further reductions in the PFS update. The Administration believes that the current Medicare physician payment system, while having served to limit spending to a degree, needs to be reformed to give physicians appropriate incentives to improve the quality and efficiency of the care provided to Medicare beneficiaries. As part of health care reform, the Administration supports comprehensive, but fiscally responsible, reforms to the physician payment formula. Consistent with this goal, the Administration announced in the FY 2010 President's Budget that it would explore the breadth of options available under current authority to facilitate such reforms, including an assessment of whether the cost of physician-administered drugs should continue to be included in the payment formula.

The statutory formula for calculating the update adjustment factor, which includes the SGR, was designed to establish reasonable limits on the growth of expenditures on physicians' services, and to provide incentives for physicians to keep the growth in expenditures within those limits. The SGR system was created by section 4503 of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33). It replaced the predecessor system, the Medicare Volume Performance System (MVPS). However, the statutory definition of ''physicians' services'' for purposes of the SGR (section 1848(f)(4)(A) of the Act) is the same as that used for the MVPS (no longer in existence, but previously at section 1848(f)(5)(A) of the Act):

> The term ''physicians' services'' includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed by a physician or in a physician's office.

Under the MVPS, we defined ''physicians' services'' to include physician-administered drugs. Therefore, we adopted the same regulatory definition at the outset of the SGR system:

> Because the scope of physicians' services covered by the SGR is the same as the scope of services that was covered by the Medicare volume performance standards, we are using the same definition of physicians' services for the SGR in this notice as we did for the Medicare volume performance standards. * * * (63 FR 59188)

Physician-administered drugs are covered under section 1861(s)(2)(A) of the Act as ''services and supplies (including drugs and biologicals which are not usually self-administered by the patient) furnished as an incident to a physician's professional services, of kinds which are commonly furnished in physicians' offices.'' Physician-administered drugs are not paid for under the PFS (56 FR 25800). However, in identifying items and services to be included in the definition of ''physicians' services'' our ''practice has been to make adjustments to the SGR for medical and other health services * * * that meet the criterion of being ''commonly performed by a physician or in a physician's office'' (66 FR 55316). Because ''incident to'' drugs are commonly furnished in physicians' offices, we elected to continue to include them in the definition of ''physicians' services'' for the SGR. Similarly, clinical diagnostic laboratory tests, which are not paid for under the PFS, have always been included in the definition of ''physicians' services'' for purposes of the SGR.

Historically, growth in the cost of prescription drugs has far outpaced growth in the cost of other physicians' services. From the 1st quarter of 1997 through the 1st quarter of 2005, the average annual growth in Medicare spending on drugs included in the SGR was 22 percent compared to 6 percent for all services (including drugs) included in the SGR. As a result, since the inception of the SGR methodology, prescription drugs have accounted for an increasingly disproportionate amount of the growth in spending on physicians' services. At the time, we made the decision to include physician-administered drugs in the definition of ''physicians' services'' used to compute the SGR, these drugs represented a much smaller volume of Medicare spending than they have in subsequent years. In the CY 2003 PFS final rule with comment period, we estimated that drugs would represent 7.3 percent of 2001 SGR spending (67 FR 80031). In the CY 2006 PFS final rule with comment period, we estimated that drugs would represent 9.9 percent of 2004 SGR spending. In the CY 2007 PFS final rule with comment period, we stated that ''commenters noted that expenditures on these drugs increased from $1.8 billion in 1996, to $8.6 billion in 2004'' (71 FR 69755). These figures clearly demonstrate that spending on physician-administered drugs has been growing at much higher rates than spending for all other PFS services and has contributed significantly to the deviation between target and actual spending, as well as to the large projected reductions in future PFS updates. There could be many reasons for the disproportionate growth in expenditures for drugs—many of which we could not have anticipated when we decided to include drugs in the SGR. In the CY 2006 PFS final rule with comment period (70 FR 70307), we summarized public comments on the proposed rule that stated that growth in Medicare spending on drugs is driven primarily by the introduction of expensive new drugs to the Medicare population and extensive marketing (including direct-to-consumer advertising). Given the significant and disproportionate impact that the inclusion of drugs has had on the SGR system, we believe it would be appropriate to revise the definition of physicians' services for purposes of the SGR.

As previously noted, the statutory definition of ''physicians' services'' for purposes of determining allowed expenditures and the SGR (section 1848(f)(4)(A) of the Act) states:

> The term ''physicians' services'' includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed by a physician or in a physician's office.

The statute clarifies that the term ''physicians' services'' includes items and services ''specified by the Secretary.'' Therefore, we believe the statute provides the Secretary with clear discretion to decide whether physician-administered drugs should be included or excluded from the definition of ''physicians' services.'' As the statute affords the Secretary clear discretion, we are proposing, in anticipation of enactment of legislation to provide fundamental reforms to Medicare physician payments, to remove physician-administered drugs from the definition of ''physicians' services'' in section 1848(f)(4)(A) of the Act for purposes of computing the SGR and levels of allowed expenditures and actual expenditures in all future years.

Moreover, given the past effect of spending growth for physician-administered drugs on future PFS updates, in order to effectuate fully the Secretary's policy decision to remove drugs from the definition of

''physicians' services'' in section 1848(f)(4)(A) of the Act, it is reasonable to remove drugs from the calculation of allowed and actual expenditures for all prior years.

We note the term ''actual expenditures'' is not defined in the statute nor are there any statutory limitations on the Secretary's ability to recompute actual expenditures to reflect changes in the amount of actual expenditures. On several occasions, we have made revisions to the amount of actual expenditures to reflect new information regarding spending on physicians' services. For instance, in the CY 2002 PFS final rule with comment period (66 FR 55314), we indicated that a number of new procedures were inadvertently not included in the measurement of actual expenditures beginning in 1998. We determined that spending for these codes must be included in actual expenditures for historical, current, and future periods. Similarly, in the CY 2009 PFS final rule with comment period, we discovered that fifteen procedure codes were inadvertently omitted from the measurement of actual expenditures beginning in 1998 (73 FR 69902). Again, we stated that spending for these codes must be included in actual expenditures for historical, current, and future periods.

Under section 1848(d)(3)(C)(i) of the Act, the level of allowed expenditures during the base year (April 1, 1996 through March 31, 1997) is equal to the actual expenditures for this period. Thus, as there are no statutory restrictions on the Secretary's ability to recompute actual expenditures to remove the costs associated with physician-administered drugs, the Secretary also has authority to remove these drugs from the calculation of allowed expenditures during the base year. Allowed expenditures in a year are based on the allowed expenditures in the prior year, updated by the SGR as specified in section 1848(d)(3)(C)(ii) of the Act for FY 1998 through FY 2000, and section 1848(d)(4)(C)(iii) for all subsequent years. Thus, once the Secretary has revised the level of allowed expenditures during the base year (as is authorized under the statute), it is reasonable to carry this revision through into all subsequent years. As the statute affords the Secretary flexibility to remove drugs from the calculation of allowed expenditures retrospectively to the base year, we are proposing to remove drugs from the calculation of allowed and actual expenditures under sections 1848(d)(3)(C) and 1848(d)(4) of the Act retrospectively to the 1996/1997 base year in order to eliminate the disproportionate impact that the large past increases in the costs attributable to physician-administered drugs would otherwise have upon future PFS updates. Further, the proposal would remove drugs from the calculation of the SGR beginning with 2010.

We note that the Secretary may choose not to finalize the proposal described above or may choose to modify the proposal in the final rule, consistent with rulemaking principles, in light of new policy developments, new information, or changed circumstances.

We currently estimate that the statutory formula used to determine the physician update will result in a CY 2010 conversion factor of $28.3208 and a PFS update of −21.5 percent. Under this proposal, removing physician-administered drugs from allowed and actual expenditures for all prior years will not change the projected −21.5 percent physician payment rate update for services furnished on or after January 1, 2010. This proposal would, however, reduce the past discrepancy between actual and target expenditures. As a result, it would reduce the number of years in which physicians are projected to experience a negative update. We note that this proposal does not mean that we are making any changes to PFS rates applicable in prior years. Rather, we are proposing to remove drugs from the calculation of allowed and actual expenditures since the 1996/1997 base year so that past year increases in drug spending would have no affect on the determination of future PFS rates.

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs):

A. ICRs Regarding Pulmonary Rehabilitation Program: Conditions for Coverage (§ 410.47)

Section 410.47(c) lists the components of a pulmonary rehabilitation program. Specifically, § 410.47(c)(3) through (c)(5) discuss psychosocial assessments, outcome assessments and individualized treatment plans, respectively, and the role of these tools in pulmonary rehabilitation programs. The burden associated with meeting the requirements for conducting psychosocial assessments, outcome assessments, and individualized treatment plans is the time and effort necessary for providers to document the necessary information in the patient record. While these requirements are subject to the PRA, we believe the associated burden is exempt as stated under 5 CFR 1320.3(b)(2). Psychosocial assessments, outcome assessments and individualized treatment plans are routine tools used in pulmonary rehabilitation programs and the practice of using these tools is generally recognized as an industry standard as part of usual and customary business practices.

B. ICRs Regarding Kidney Disease Education Services (§ 410.48)

Proposed § 410.48(f) states qualified persons will develop outcomes assessments designed to:

- Measure beneficiary knowledge about chronic kidney disease (CKD) and its treatment;
- Assess program effectiveness of preparing the beneficiary to make informed decisions about their healthcare options related to CKD; and
- Assess program effectiveness in meeting the communication needs of underserved populations, including persons with disabilities, persons with limited English proficiency, and persons with health literacy needs.

We are proposing that the assessment will be administered to the beneficiary during one of the kidney disease education (KDE) sessions prescribed by the referring physician. The assessments will be made available to CMS upon request.

The burden associated with these requirements is the time and effort necessary to conduct an outcomes assessment, maintain record of the

assessment, and to make the documentation available to CMS upon request. At this time, CMS is not able to accurately quantify the burden because we cannot estimate the number of entities that must comply with these requirements. Additionally, we are trying to determine if the use and maintenance of outcome assessments in KDE services is a standard industry business practice. Our preliminary research gathered during a CMS Open Door Forum held on November 6, 2008 and a stakeholders meeting hosted by the Agency for Healthcare Research and Quality (AHRQ) on December 16, 2008 indicates that outcome assessments are used by most but not all of the entities bound by the proposed requirements in § 410.48. We welcome comments pertaining to this issue and will reevaluate all related PRA burden issues in the final rule stage of rulemaking.

C. ICRs Regarding Cardiac Rehabilitation Program and Intensive Cardiac Rehabilitation Program: Conditions of Coverage (§ 410.49)

Proposed § 410.49(b)(2) lists the required components of a cardiac rehabilitation program. Four of the five required components, including cardiac risk factor modification, psychosocial assessments, outcomes assessments and individualized treatment plans, impose information collection burdens. The burden associated with these requirements is the time and effort necessary to providers to customize each patient's cardiac risk modification program. Additionally, there is burden associated with conducting psychosocial assessments and outcome assessments and drafting individualized treatment plans. Although section 144(a) of the MIPPA sets forth these information collection requirements, we believe the associated information collection burden is exempt as stated under 5 CFR 1320.3(b)(2). Performing cardiac risk modification, psychosocial assessments, outcome assessments, and individualized treatment plans are routine tools used in cardiac rehabilitation programs. As stated earlier in the preamble of this proposed rule, intensive cardiac rehabilitation programs typically involve the same elements as general cardiac rehabilitation programs, but are furnished in highly structured environments in which sessions of the various components may be combined for longer periods of cardiac rehabilitation and also may be more rigorous. The ICRs and associated burden are generally recognized as an industry standard as part of usual and customary business practices.

Proposed § 410.49(c)(1) states that to be designated an intensive cardiac rehabilitation program, a program in an approved setting must apply for designation. To be designated as an intensive cardiac rehabilitation program, the program must demonstrate through peer-reviewed, published research that it accomplishes one or more of the requirements listed in § 410.49(c)(1)(i) through (iv). As required by § 410.49(c)(3), sites must demonstrate that patients enrolled continue to achieve beneficial outcomes by submitting outcomes data annually from the date of approval as an intensive cardiac rehabilitation site to ensure that intensive cardiac rehabilitation programs maintain the designated quality of rehabilitation.

The burden associated with the requirements in § 410.49(c) is the time and effort necessary for a program to demonstrate through peer-reviewed, published research that it accomplishes one or more of the requirements listed in § 410.49(c)(1)(i) through (iv) and the time and effort necessary to annually submit outcomes data. At this time, CMS is not able to accurately quantify the burden because we cannot estimate the number of entities that will seek designation as intensive cardiac rehabilitation programs. We welcome comments pertaining to this issue and will reevaluate all related PRA burden issues in the final rule stage of rulemaking.

D. ICRs Regarding Imaging Accreditation (§ 414.68)

Proposed § 414.68(b) contains the application and reapplication procedures for accreditation organizations. Specifically, an independent accreditation organization applying for approval or reapproval of authority to survey suppliers for purposes of accrediting suppliers furnishing the technical component (TC) of advanced diagnostic imaging services must furnish CMS with all of the information listed in proposed § 414.68(b)(1) through (14). The requirements include but are not limited to reporting, notification, documentation, and survey requirements.

The burden associated with the proposed collection requirements in § 414.68(b) is the time and effort necessary to develop, compile and submit the information listed in § 414.68(b)(1) through (14). We believe that 3 entities will choose to comply with these requirements. We estimate that it will take each of the 3 entities, 80 hours to submit a complete application for approval or reapproval authority to become an accrediting organization approved by CMS.

Proposed § 414.68(c) contains the information collection requirements pertaining to CMS approved accrediting organizations. An accrediting organization approved by CMS must undertake all of the activities listed in § 414.68(c)(1) through (6). The burden associated with the proposed collection requirements in § 414.68(c) is the time and effort necessary to develop, compile and submit the information listed in § 414.68(c)(1) through (6). We believe that 3 entities will choose to comply with these requirements. We estimate that it will take each of the 3 entities, 80 hours to submit the required information on an ongoing basis.

Proposed § 414.68(d)(1) states that CMS or its contractor may conduct an audit of an accredited supplier, examine the results of a CMS approved accreditation organization's survey of a supplier, or observe a CMS approved accreditation organization's onsite survey of a supplier, in order to validate the CMS approved accreditation organizations accreditation process. The burden associated with this requirement is the time and effort necessary for an accrediting organization to comply with the components of the validation audit. While this requirement is subject to the PRA, we believe the associated burden is exempt as stated in 5 CFR 1320.3(h)(6). The burden associated with a request for facts addressed to a single person, as defined in 5 CFR 1320.3(j), is not subject to the PRA.

As stated in proposed § 414.68(e)(1), an accreditation organization dissatisfied with a determination that its accreditation requirements do not provide or do not continue to provide reasonable assurance that the suppliers accredited by the organization meet the applicable quality standards is entitled to a reconsideration. CMS reconsiders any determination to deny, remove, or not to renew the approval of deeming authority to an accreditation organization if the accrediting organization files a written request for reconsideration by its authorized officials or through its legal representative. The written request must be filed within 30 calendar days of the receipt of CMS' notice of an adverse determination or nonrenewal. In addition, the request must also specify the findings or issues with which the accreditation organization disagrees and the reasons for the disagreement.

The burden associated with this requirement is the time and effort necessary for an accrediting organization to file develop and file written request for reconsideration.

While this requirement is subject to the PRA, the associated burden is exempt under 5 CFR 1320.4. The information in question is being collected as a result of an administrative action; accrediting organizations are submitting requests for reconsideration after receiving a notice of an adverse determination or nonrenewal.

E. ICRs Regarding Payment Rules (§ 414.408)

Proposed § 414.408(j)(5) contains the notification requirements for suppliers electing to become grandfathered suppliers. Specifically, § 414.408(j)(5)(i) states that a noncontract supplier that elects to become a grandfathered supplier must provide a 30-day written notification to each Medicare beneficiary that resides in a competitive bidding area and is currently renting a competitively bid item from that supplier. The 30-day notification to the beneficiary must meet the requirements as listed in § 414.408(j)(5)(i)(A) through (G).

Subsequent to the initial 30-day notice to the beneficiary, as required by § 414.408(j)(5)(ii), suppliers must also obtain and maintain a record of the beneficiary's election choice, the date the choice was made, and the manner through which the beneficiary communicated his or her choice. Additionally, § 414.408(j)(5)(iii) states that if a beneficiary chooses not to continue to receive a grandfathered item(s) from his or her current supplier, the supplier must provide the beneficiary with two more notices prior to the supplier picking up its equipment. The supplier must provide a 10-day notification and a 2-day notification. These notification requirements must meet the criteria listed in § 414.408(j)(5)(iii)(A) through (C).

Section § 414.408(j)(5)(iv) requires suppliers that elect to become grandfathered suppliers to provide a written notification to CMS of its election decision. The notification must meet the requirements as specified in § 414.408(j)(5)(iv)(A) through (D).

The burden associated with the information collection requirements contained in proposed § 414.408(j)(5) is the time and effort necessary for a noncontract supplier to make the aforementioned notifications to both beneficiaries and CMS. We estimate that 1,305 suppliers will elect to become grandfathered suppliers. Similarly, we estimate that each grandfathered supplier will need to make an average of 53 notifications based on an average of 52 beneficiaries per supplier and one notice to CMS. We estimate that it will take 2 hours to develop the notification to the beneficiary and 2 hours to develop the notification to CMS. Similarly, we estimate that each notification will take 15 minutes to send. The total estimated burden associated with each of the 1305 suppliers complying with the requirements in proposed § 414.408(j)(5) is 17.25 hours per supplier for a total of 22,511 hours.

Proposed § 414.408(j)(6) contains the information collection requirements pertaining to suppliers that choose not to become grandfathered suppliers. A noncontract supplier that elects not to become a grandfathered supplier is required to pick up the item it is currently renting to the beneficiary from the beneficiary's home after proper notification. Proper notification includes a 30-day, a 10-day, and a 2-day notice of the supplier's decision not to become a grandfathered supplier to its Medicare beneficiaries who are currently renting certain DME competitively bid item(s) and who reside in a CBA. These notifications must meet all of the requirements listed in proposed § 414.408(j)(5)(i) and (ii) for the 30-day, 10-day and 2-day notices that must be sent by suppliers who decide to be grandfathered suppliers. However, there are exceptions regarding the 30-day notice for noncontract suppliers electing not to become grandfathered suppliers. The exceptions are listed in proposed § 414.408(j)(6)(iii)(A) through (C). In addition, suppliers must also comply with the criteria listed in proposed § 414.408(j)(6)(iv).

The burden associated with the proposed information collection requirements in § 414.408(j)(6) is the time and effort necessary for a supplier to make the required notifications to beneficiaries. We estimate that 145 suppliers will not elect to become grandfathered suppliers. Similarly, we estimate that each nongrandfathered supplier will need to make an average of 156 notifications based on an average of 52 beneficiaries per supplier. We estimate that it will take 2 hours to develop the 30-day notification to the beneficiary and 15 minutes to send out each notification. The 10-day notification will take approximately 15 minutes and the 2-day will take approximately 15 minutes. We estimate to send out all 3 notifications it will take a total of approximately 45 minutes. The total burden associated with the requirements in proposed § 414.408(j)(6) is approximately 5,945 hours.

F. ICRs Regarding Claims for Damages (§ 414.425)

Proposed § 414.425(a) states that any aggrieved supplier, including a member of a network that was awarded a contract for the Round 1 Durable Medical Prosthetics, Orthotics, and Supplies Competitive Bidding Program (DMEPOS CBP), may file a claim under this section for certain alleged damages arising out of MIPPA's termination of the Round 1 DMEPOS CBP contracts. Section 414.425(b) states that a completed claim, including all documentation, must be filed within 90 days of the effective date of the final rule on damages, unless that day is a holiday or Sunday in which case it will revert to the next business day. Section 414.425(c) lists the required documentation for submitting a claim.

The burden associated with this requirement is the time and effort necessary to gather required documentation as specified in § 414.425(c) and submit a claim for damages. This requirement is for a one-time process that will only impact those suppliers who were awarded a contract and were potentially damaged by the termination of their contracts by MIPPA. We awarded contracts to 329 suppliers. We expect that it will take approximately 3 hours for a supplier to gather the necessary documents and to file a claim. We anticipate that anywhere between 5 and 250 suppliers may submit a claim for damages.

While this requirement is subject to the PRA, we believe the associated burden is exempt under 5 CFR 1320.4. The information in question is being collected as a result of an administrative action; suppliers are submitting claims for damages caused by the termination of contracts awarded in 2008 under the DMEPOS Competitive Bidding program that were terminated as a result of section 154(a)(1)(A)(iv) of the MIPPA.

G. ICRs Dispute Resolution and Process for Suspension or Termination of Approved CAP Contract and Termination of Physician Participation Under Exigent Circumstances (§ 414.917)

As stated in proposed § 414.97, an approved CAP vendor may appeal that termination by requesting a reconsideration. A determination must be made as to whether the approved CAP vendor has been meeting the service and quality obligations of its CAP contract. The approved CAP vendor's contract will remain suspended during the reconsideration process.

The burden associated with this requirement is the time and effort necessary for a CAP vendor to request a reconsideration of the termination. While this requirement is subject to the PRA, we believe the associated burden is exempt under 5 CFR 1320.4. The burden associated with collecting information subsequent to an administrative action is not subject to the PRA.

H. ICRs Regarding Compendia for Determination of Medically-Accepted Indications for Off-Label Uses of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen (§ 414.930)

As stated in the definition for a publicly transparent process for evaluating therapies in proposed § 414.930(a), a compendium must make the following materials available to the public on its Web site, coincident with the compendium's publication of the related recommendation:

(i) The application for inclusion of a therapy including criteria used to evaluate the request.

(ii) A listing of all the evidentiary materials reviewed or considered by the compendium pursuant to the application.

(iii) A listing of all individuals (and their affiliations and sources of financial support) who have substantively participated in the development of compendia recommendations.

(iv) Transcripts of meetings and records of the votes, including abstentions, related to the therapeutic recommendation on the application.

The definition for a publicly transparent process for identifying conflicts of interests in proposed § 414.930(a), states that a compendium must make the following materials available to the public, coincident with the compendium's publication of the related recommendation:

(i) Direct or indirect financial relationships that exist between individuals who have substantively participated in the development of compendia recommendations and the applicant (for example, the manufacturer or seller of the drug or biological being reviewed by the compendium). This may include compensation arrangements such as salary, grant, contract, or collaboration agreements between individuals who have substantively participated in the development of compendia recommendations.

(ii) Ownership or investment interests of individuals who have substantively participated in the development of compendia recommendations and the applicant (for example, the manufacturer or seller of the drug or biological being reviewed by the compendium).

The requirements in proposed § 414.930(a) constitute third-party disclosures. While third-party disclosures are subject to the PRA, we believe the associated burden is exempt under 5 CFR 1320.3(c)(4). Less than 10 persons or entities within a 12-month period will be required to comply.

TABLE 37—ESTIMATED ANNUAL REPORTING AND RECORDKEEPING BURDEN

Regulation section(s)	OMB control No.	Respondents	Responses	Burden per response (hours)	Total annual burden (hours)
§ 414.68(b)	0938–New	3	3	80	240
§ 414.68(c)	0938–New	3	3	80	240
§ 414.408(j)(5)	0938–New	1305	69,165	17.25	22,511
§ 414.408(j)(6)	0938–New	145	22,620	41	5,945
Total					28,936

If you comment on these information collection and recordkeeping requirements, please do either of the following:

1. Submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule; or

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, *Attention:* CMS Desk Officer, [CMS–1413–P]; *Fax:* (202) 395–6974; or *E-mail: OIRA_submission@omb.eop.gov*.

Additional Information Collection Requirements

This proposed rule imposes collection of information requirements as outlined in the regulation text and specified above. However, this proposed rule also makes reference to several associated information collections that are not discussed in the regulation text contained in this document. The following is a discussion of these information collections, some of which have already received OMB approval.

Part B Drug Payment

The discussion of average sales price (ASP) issues in section II.H.1 of this proposed rule does not contain any new information collection requirements with respect to payment for Medicare Part B drugs and biologicals under the ASP methodology. Drug manufacturers are required to submit ASP data to us on a quarterly basis. The ASP reporting requirements are set forth in section 1927(b) of the Act. The burden associated with this requirement is the time and effort required by manufacturers of Medicare Part B drugs and biologicals to calculate, record, and submit the required data to CMS. While the burden associated with this requirement is subject to the PRA, it is currently approved under OMB control number 0938–0921. A revision of the currently approved information collection request is currently under review at OMB.

Competitive Acquisition Program (CAP)

Section II.H.2. of this proposed rule discusses issues related to the competitive acquisition program for Part B drug payment. There are no new information collection requirements associated with the CAP; however, there are several previously approved information collection requests (ICR) associated with the CAP.

TABLE 38—OMB CONTROL NUMBERS

Program component	OMB control number	Expiration date
Medicare Part B Drug and Biological CAP	0938–0954	06/30/2011

TABLE 38—OMB CONTROL NUMBERS—Continued

Program component	OMB control number	Expiration date
Medicare Part B Drug and Biological Competitive Acquisition Program Applications [1]	0938–0955	08/31/2009
Competitive Acquisition Program (CAP) for Medicare Part B Drugs: CAP Physician Election Agreement	0938–0987	12/31/2011

[1] An extension of the currently approved ICR is currently in the middle of the mandatory 60-day **Federal Register** notice and comment period. The ICR will be submitted to OMB for review and approval prior to the expiration date.

Physician Quality Reporting Initiative (PQRI)

Section II.G.2. of this proposed rule discusses the background of the PQRI, provides information about the measures proposed to be available to eligible professionals who choose to participate in the 2010 PQRI, and the proposed criteria for satisfactory reporting in 2010. Beginning on January 1, 2010, the Secretary is also required by section 1848(m)(3)(C) of the Act, to establish and have in place a process under which eligible professionals in a group practice (as defined by the Secretary) shall be treated as satisfactorily submitting data on quality measures under the PQRI.

With respect to satisfactory submission of data on quality measures by eligible professionals, eligible professionals include physicians, other practitioners as described in section 1842(b)(18)(c) of the Act, physical and occupational therapists, qualified speech-language pathologists, and qualified audiologists. Eligible professionals may choose whether to participate and, to the extent they satisfactorily submit data on quality measures for covered professional services, they can qualify to receive an incentive payment. To qualify to receive an incentive payment for 2010, the eligible professional must meet one of the criteria for satisfactory reporting described in sections II.G.2.e. and II.G.2.f. of this proposed rule.

For individual eligible professionals, the burden associated with the requirements of this voluntary reporting initiative is the time and effort associated with eligible professionals identifying applicable PQRI quality measures for which they can report the necessary information. We believe it is difficult to accurately quantify the burden because it would vary with each eligible professional by the number of measures applicable to the eligible professional, the eligible professional's familiarity and understanding of the PQRI, and experience with participating in the PQRI. In addition, eligible professionals may employ different methods for incorporating the use of quality data codes into the office work flows.

We believe the burden associated with participating in PQRI has declined for those familiar with the program and who have satisfactorily participated in the 2007 PQRI and/or the 2008 PQRI. However, because we anticipate even greater participation in the 2010 PQRI, including participation by eligible professionals who are participating in PQRI for the first time in 2010, we will assign 3 hours as the amount of time needed for eligible professionals to review the list of PQRI quality measures, identify the applicable measures for which they can report the necessary information, review the measure specifications for those measures applicable to the eligible professional, and incorporate the use of quality data codes for the measures on which the eligible professional plans to report into the office work flows. Information from the Physician Voluntary Reporting Program (PVRP), which was a predecessor to the PQRI, indicated an average labor cost of $50 per hour. To account for salary increases over time, we will use an average practice labor cost of $55 per hour in our estimates based on an assumption of an average annual increase of approximately 3 percent. Thus, we estimate the cost for an eligible professional to review the list of PQRI quality measures, identify the applicable measures for which they can report the necessary information, review the measure specifications for those measures applicable to the eligible professional, and incorporate the use of quality data codes for the measures on which the eligible professional plans to report into the office work flows to be approximately $165 per eligible professional ($55 per hour × 3 hours).

We continue to expect the ongoing costs associated with PQRI participation to decline based on an eligible professional's familiarity with and understanding of the PQRI, experience with participating in the PQRI, and increased efforts by CMS and stakeholders to disseminate useful educational resources and best practices.

In addition, for claims-based reporting, eligible professionals must gather the required information, select the appropriate quality data codes, and include the appropriate quality data codes on the claims they submit for payment. The PQRI will collect quality data codes as additional (optional) line items on the existing HIPAA transaction 837–P and/or CMS Form 1500. We do not anticipate any new forms and no modifications to the existing transaction or form. We also do not anticipate changes to the 837–P or CMS Form 1500 for CY 2010.

Because this is a voluntary program, it is impossible to estimate with any degree of accuracy how many eligible professionals will opt to participate in the PQRI in CY 2010. Information from the ''PQRI 2007 Reporting Experience Report,'' which is available on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI*, indicates that nearly 110,000 unique TIN/NPI combinations attempted to submit PQRI quality measures data via claims for the 2007 PQRI. Therefore, for purposes of conducting a burden analysis for the 2010 PQRI, we will assume that all eligible professionals who attempted to participate in the 2007 PQRI will also attempt to participate in the 2010 PQRI.

Moreover, the time needed for an eligible professional to review the quality measures and other information, select measures applicable to his or her patients and the services he or she furnishes to them, and incorporate the use of quality data codes into the office work flows is expected to vary along with the number of measures that are potentially applicable to a given professional's practice. Since eligible professionals are generally required to report on at least 3 measures to earn a PQRI incentive, we will assume that each eligible professional who attempts to submit PQRI quality measures data is attempting to earn a PQRI incentive payment and that each eligible professional reports on an average of 3 measures for this burden analysis.

Based on our experience with the PVRP, we continue to estimate that the time needed to perform all the steps necessary to report each measure (that is, reporting the relevant quality data code(s) for a measure) on claims ranges from 15 seconds (0.25 minutes) to over 12 minutes for complicated cases and/

or measures, with the median time being 1.75 minutes. Information from the PVRP indicates that the cost associated with this burden ranges from $0.21 in labor time to about $10.06 in labor time for more complicated cases and/or measures, with the cost for the median practice being $0.90.

The total estimated annual burden for this requirement will also vary along with the volume of claims on which quality data is reported. Since we propose to require eligible professionals to report at least one of their selected measures for at least 15 Medicare Part B FFS patients in order to satisfactorily report, then, for this burden analysis, we will assume that for each measure, the eligible professional reports the quality data codes on 15 cases. The actual number of cases on which an eligible professional would be required to report quality measures data will vary, however, with the eligible professional's patient population and the types of measures on which the eligible professional chooses to report (each measure's specifications includes a required reporting frequency).

Based on the assumptions discussed above, we estimate the total annual burden per eligible professional associated with claims-based reporting to range from 191.25 minutes, or 3.2 hours [(0.25 minutes per measure × 3 measures × 15 cases per measure) + 3 hours] to 720 minutes, or 12 hours [(12 minutes per measure × 3 measures × 15 cases per measure) + 3 hours]. We estimate the total annual cost per eligible professional associated with claims-based reporting to range from $174.45 [($0.21 per measure × 3 measures × 15 cases per measure) + $165] to $617.70 [($10.06 per measure × 3 measures × 15 cases per measure) + $165].

For registry-based reporting, there would be no additional burden for eligible professionals to report data to a registry as eligible professionals opting for registry-based reporting would more than likely already be reporting data to the registry. Little, if any, additional data would need to be reported to the registry for purposes of participation in the 2010 PQRI. However, eligible professionals would need to authorize or instruct the registry to submit quality measures results and numerator and denominator data on quality measures to CMS on their behalf. We estimate that the time and effort associated with this would be approximately 5 minutes for each eligible professional that wishes to authorize or instruct the registry to submit quality measures results and numerator and denominator data on quality measures to CMS on their behalf.

Registries interested in submitting quality measures results and numerator and denominator data on quality measures to CMS on their participants' behalf in 2010 would need to complete a self-nomination process in order to be considered ''qualified'' to submit on behalf of eligible professionals unless the registry was qualified to submit on behalf of eligible professionals for the 2009 PQRI and did so successfully. We estimate that the proposed self-nomination process for qualifying additional registries to submit on behalf of eligible professionals for the 2010 PQRI involves approximately 1 hour per registry to draft the letter of intent for self-nomination. It is estimated that each self-nominated entity will also spend 2 hours for the interview with CMS officials and 2 hours for the development of a measure flow. However, the time it takes to complete the measure flow could vary depending on the registry's experience. Additionally, part of the self-nomination process involves the completion of an XML submission by the registry, which is estimated to take approximately 5 hours, but may vary depending on the registry's experience. We estimate that the registry staff involved in the registry self-nomination process have an average labor cost of $50 per hour. Therefore, assuming the total burden hours per registry associated with the registry self-nomination process is 10 hours, we estimate the total cost to a registry associated with the registry self-nomination process to be approximately $500 ($50 per hour × 10 hours per registry).

The burden associated with the registry-based reporting requirements of this voluntary reporting initiative is the time and effort associated with the registry calculating quality measure results from the data submitted to the registry by its participants and submitting the quality measures results and numerator and denominator data on quality measures to CMS on behalf of their participants. The time needed for a registry to review the quality measures and other information, calculate the measures results, and submit the measures results and numerator and denominator data on the quality measures on their participants behalf is expected to vary along with the number of eligible professionals reporting data to the registry and the number of applicable measures. However, we believe that registries already perform many of these activities for their participants. The number of measures that the registry intends to report to CMS and how similar the registry's measures are to CMS' PQRI measures will determine the time burden to the registry.

For EHR-based reporting, the eligible professional must review the quality measures on which we will be accepting PQRI data extracted from EHRs, select the appropriate quality measures, extract the necessary clinical data from his or her EHR, and submit the necessary data to the CMS-designated clinical data warehouse. Because this manner of reporting quality data to CMS would be new to PQRI for 2010 and participation in this reporting initiative is voluntary, we believe it is difficult to estimate with any degree of accuracy how many eligible professionals will opt to participate in the PQRI through the EHR mechanism in CY 2010. The time needed for an eligible professional to review the quality measures and other information, select measures applicable to his or her patients and the services he or she furnishes to them is expected to be similar for EHR-based reporting and claims-based reporting (that is, 3 hours). Once the EHR is programmed by the vendor to allow data submission to CMS, the burden to the eligible professional associated with submission of data on PQRI quality measures should be minimal.

An EHR vendor interested in having their product(s) be used by eligible professionals to submit quality measures results and numerator and denominator data on quality measures to CMS were required to complete a self-nomination process in order for the vendor's product(s) to be considered ''qualified'' for 2010. We are unable to accurately quantify the burden associated with the EHR self-nomination process as there is variation regarding the technical capabilities and experience among vendors. For purposes of this burden analysis, however, we estimate that the time required for an EHR vendor to complete the self-nomination process will be similar to the time required for registries to self-nominate that is approximately 10 hours at $50 per hour for a total of $500 per EHR vendor ($50 per hour × 10 hours per EHR vendor).

The burden associated with the EHR-based reporting requirements of this voluntary reporting initiative is the time and effort associated with the EHR vendor programming its EHR product(s) to extract the clinical data that the eligible professional needs to submit to CMS for purposes of reporting 2010 PQRI quality measures. The time needed for an EHR vendor to review the quality measures and other information

and program each qualified EHR product to enable eligible professionals to submit PQRI quality measures data to the CMS-designated clinical data warehouse will be dependent on the EHR vendor's familiarity with PQRI, the vendor's system capabilities, as well as the vendor's programming capabilities. Some vendors already have these necessary capabilities and for such vendors, we estimate the total burden hours to be 40 hours at a rate of $50 per hour for a total burden estimate of $2,000 ($50 per hour × 40 hours per vendor). However, given the variability in the capabilities of the vendors, we believe a more conservative estimate for those vendors with minimal experience would be approximately 200 hours at $50 per hour, for a total estimate of $10,000 per vendor ($50 per hour × 200 hours per EHR vendor).

With respect to the proposed process for group practices to be treated as satisfactorily submitting quality measures data under the 2010 PQRI discussed in section II.G.2. of this proposed rule, group practices interested in participating in the 2010 PQRI through the group practice reporting option would need to complete a self-nomination process similar to the self-nomination process required of registries and EHR vendors. Therefore, we estimate that the proposed self-nomination process for the group practices for the 2010 PQRI involves approximately 2 hours per group practice to draft the letter of intent for self-nomination, gather the requested TIN and NPI information, and provide this requested information. It is estimated that each self-nominated entity will also spend 2 hours undergoing the vetting process with CMS officials. We assume that the group practice staff involved in the group practice self-nomination process have an average practice labor cost of $55 per hour. Therefore, assuming the total burden hours per group practice associated with the group practice self-nomination process is 4 hours, we estimate the total cost to a group practice associated with the group practice self-nomination process to be approximately $220 ($55 per hour × 4 hours per group practice).

The burden associated with the group practice reporting requirements of this voluntary reporting initiative is the time and effort associated with the group practice submitting the quality measures data. For physician group practices, this would be the time associated with the physician group completing the proposed data collection tool. The information collection components of this data collection tool have been reviewed by OMB and are currently approved under OMB control number 0938–0941, with an expiration date of December 31, 2011, for use in the Physician Group Practice, Medicare Care Management Performance (MCMP), and EHR demonstrations. Based on burden estimates for the PGP demonstration, which uses the same data submission methods as what we have proposed, we estimate the burden associated with a physician group completing the data collection tool would be approximately 79 hours per physician group. Therefore, we estimate the total annual burden hours per physician group would be approximately 83 hours (4 hours for self-nomination + 79 hours for data submission). Based on an average labor cost of $55 per physician group, we estimate the cost per physician group associated with participating in the proposed PQRI group practice reporting option would be $4,565 ($55 per hour × 83 hours per group practice).

We invite comments on this burden analysis, including the underlying assumptions used in developing our estimates.

The Electronic Prescribing (E-Prescribing) Incentive Program

We believe it is difficult to estimate with any degree of accuracy how many eligible professionals will opt to participate in the E-Prescribing Incentive Program in CY 2010. Information from the ''PQRI 2007 Reporting Experience Report,'' which is available on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI*, indicates that nearly 110,000 unique TIN/NPI combinations attempted to submit PQRI quality measures data via claims for the 2007 PQRI. Therefore, for purposes of conducting a burden analysis for the 2010 E-Prescribing Incentive Program, we will assume that as many eligible professionals who attempted to participate in the 2007 PQRI will attempt to participate in the 2010 E-Prescribing Incentive Program. As such, we can estimate that nearly 110,000 unique TIN/NPI combinations will participate in the 2010 E-Prescribing Incentive Program.

Section II.G.5. of this proposed rule discusses the background of the E-Prescribing Incentive Program. Section II.G.5.c. of this proposed rule provides information on how we propose eligible professionals can qualify to be considered a successful e-prescriber in 2010 in order to earn an incentive payment. Similar to the PQRI, the E-Prescribing Incentive Program is a voluntary initiative. Eligible professionals may choose whether to participate and, to the extent they meet (1) certain thresholds with respect to the volume of covered professional services furnished and (2) the criteria to be considered a successful e-prescriber described in section II.G.5.c. of this proposed rule, they can qualify to receive an incentive payment for 2010.

For the 2010 E-Prescribing Incentive Program, as discussed in section II.G.5. of this proposed rule, we propose that each eligible professional would need to report the G-code indicating that at least one prescription generated during an encounter was electronically submitted at least 25 instances during the reporting period. Similar to PQRI, this measure would be reportable through claims-based reporting, registry-based reporting, or through EHRs, if we finalize the proposed EHR-based reporting mechanism for PQRI.

Similar to claims-based reporting for the PQRI, we estimate that the burden associated with the requirements of this new incentive program is the time and effort associated with eligible professionals determining whether the electronic prescribing quality measure applies to them, gathering the required information, selecting the appropriate quality data codes, and including the appropriate quality data codes on the claims they submit for payment. We expect the ongoing costs associated with participation in the E-Prescribing Incentive Program to decline based on an eligible professional's familiarity with and understanding of the E-Prescribing Incentive Program, experience with participating in the E-Prescribing Incentive Program, and increased efforts by CMS and stakeholders to disseminate useful educational resources and best practices. Since the E-Prescribing Incentive Program consists of only 1 quality measure, we will assign 1 hour as the amount of time needed for eligible professionals to review the e-prescribing measure and incorporate the use of quality data codes into their office work flows. At an average cost of approximately $55 per hour, we estimate the total cost to eligible professionals for reviewing the e-prescribing measure and incorporating the use of quality data codes into the office work flows to be approximately $55 ($55 per hour × 1 hour).

For claims-based reporting, the quality data codes will be collected as additional (optional) line items on the existing HIPAA transaction 837–P and/or CMS Form 1500. We do not anticipate any new forms and no modifications to the existing transaction or form. We also do not anticipate

changes to the 837–P or CMS Form 1500 for CY 2010.

Based on our experience with the PVRP described in section II.G.5. of this proposed rule, we estimate that the time needed to perform all the steps necessary to report the e-prescribing measure to be 1.75 minutes. We also estimate the cost to perform all the steps necessary to report the e-prescribing measure to be $0.90 based on the experience with the PVRP described above.

Based on our proposed criteria for determination of whether an eligible professional is a successful e-prescriber, we estimate that each eligible professional would report the electronic prescribing measure in 25 instances during the reporting period.

Therefore, we estimate the total annual burden per eligible professional who chooses to participate in the 2010 E-Prescribing Incentive Program through claims-based reporting of the electronic prescribing measure to be 104 minutes, or 1.73 hours [(1.75 minutes per measure × 1 measure × 25 cases per measure) + 1 hour]. The total estimated cost per eligible professional to report the electronic prescribing measure is estimated to be $77.50 [($0.90 per measure × 1 measure × 25 cases per measure) + $55].

Because registry-based reporting of the electronic prescribing measure to CMS would be new for 2010 and participation in this reporting initiative is voluntary, it is impossible to estimate with any degree of accuracy how many eligible professionals will opt to participate in the E-Prescribing Incentive Program through the registry-based reporting mechanism in CY 2010. We do not anticipate, however, any additional burden for eligible professionals to report data to a registry as eligible professionals opting for registry-based reporting would more than likely already be reporting data to the registry. Little, if any, additional data would need to be reported to the registry for purposes of participation in the 2010 E-Prescribing Incentive Program. However, eligible professionals would need to authorize or instruct the registry to submit quality measures results and numerator and denominator data on the electronic prescribing measure to CMS on their behalf. We estimate that the time and effort associated with this would be approximately 5 minutes for each eligible professional that wishes to authorize or instruct the registry to submit quality measures results and numerator and denominator data on the electronic prescribing measure to CMS on their behalf.

Based on our proposal to consider only registries qualified to submit quality measures results and numerator and denominator data on quality measures to CMS on their participants' behalf for the 2010 PQRI to be qualified to submit results and numerator and denominator data on the electronic prescribing measure for the 2010 E-Prescribing Incentive Program, there would be no need for a registry to undergo a separate self-nomination process for the E-Prescribing Incentive Program and therefore, no additional burden associated with the registry self-nomination process.

The burden associated with the registry-based reporting requirements of this voluntary reporting initiative is the time and effort associated with the registry calculating results for the electronic prescribing measure from the data submitted to the registry by its participants and submitting the quality measures results and numerator and denominator data on the electronic prescribing quality measure to CMS on behalf of their participants. The time needed for a registry to review the electronic prescribing measure and other information, calculate the measure's results, and submit the measure's results and numerator and denominator data on the measure on their participants behalf is expected to vary along with the number of eligible professionals reporting data to whom the measure applies. However, we believe that registries already perform many of these activities for their participants. Since the E-Prescribing Incentive Program consists of only one measure, we believe that the burden associated with the registry reporting the measure's results and numerator and denominator to CMS on behalf of their participants would be minimal.

For EHR-based reporting, the eligible professional must review the electronic prescribing measure, extract the necessary clinical data from his or her EHR, and submit the necessary data to the CMS-designated clinical data warehouse. Because this manner of reporting quality data to CMS would be new for 2010 and participation in this reporting initiative is voluntary, it is impossible to estimate with any degree of accuracy how many eligible professionals will opt to participate in the E-Prescribing Incentive Program through the EHR-based reporting mechanism in CY 2010. The time needed for an eligible professional to review the electronic prescribing measure and other information and determine whether the measure is applicable to his or her patients and the services he or she furnishes to them is expected to be similar for EHR-based reporting and claims-based reporting (that is, 1 hour). Once the EHR is programmed by the vendor to allow data submission to CMS, the burden to the eligible professional associated with submission of data on the electronic prescribing measure should be minimal.

Based on our proposal to consider only EHR products qualified for the 2010 PQRI to be qualified for the 2010 E-Prescribing Incentive Program, there would be no need for EHR vendors to undergo a separate self-nomination process for the E-Prescribing Incentive Program and therefore, no additional burden associated with the self-nomination process.

The burden associated with the EHR-based reporting requirements of this voluntary reporting initiative is the time and effort associated with the EHR vendor programming its EHR product(s) to extract the clinical data that the eligible professional needs to submit to CMS for purposes of reporting the 2010 electronic prescribing measure. The time needed for an EHR vendor to review the measure and other information and program each qualified EHR product to enable eligible professionals to submit data on the measure to the CMS-designated clinical data warehouse will be dependent on the EHR vendor's familiarity with the electronic prescribing measure, the vendor's system capabilities, as well as the vendor's programming capabilities. Since only EHR products qualified for the 2010 PQRI would be qualified for the 2010 E-Prescribing Incentive Program and the E-Prescribing Incentive Program consists of only one measure, we believe that any burden associated with the EHR vendor to program its product(s) to enable eligible professionals to submit data on the electronic prescribing measure to the CMS-designated clinical data warehouse would be minimal.

Finally, with respect to the proposed process for group practices to be treated as successful e-prescribers under the 2010 E-Prescribing Incentive Program discussed in section II.G.5. of this proposed rule, a group practice would be required to report the electronic prescribing measure in at least 2500 instances. Group practices have the same options as individual eligible professionals in terms of the form and manner for reporting the electronic prescribing measure (that is, group practices have the option of reporting the measure through claims, a qualified registry, or a qualified EHR product). The only difference between an individual eligible professional and group practice reporting of the

electronic prescribing measure is the number of times that a group practice is required to report the electronic prescribing measure. For group practices who are selected to participate in the 2010 E-Prescribing Incentive Program group practice reporting option and choose to do so through claims-based reporting of the electronic prescribing measure, we estimate the total annual burden to be 73.92 hours [(1.75 minutes per measure × 1 measure × 2500 cases per measure) + 1 hour]. The total estimated cost per group practice to report the electronic prescribing measure through claims-based reporting is estimated to be $2,305 [($0.90 per measure × 1 measure × 2500 cases per measure) + $55].

For group practices who are selected to participate in the 2010 E-Prescribing Incentive Program group practice reporting option and choose to do so through registry-based reporting of the electronic prescribing measure, we do not anticipate any additional burden to report data to a registry as group practices opting for registry-based reporting would more than likely already be reporting data to the registry. Little, if any, additional data would need to be reported to the registry for purposes of participation in the 2010 E-Prescribing Incentive Program. However, group practices would need to authorize or instruct the registry to submit quality measures results and numerator and denominator data on the electronic prescribing measure to CMS on their behalf. We estimate that the time and effort associated with this would be approximately 5 minutes for each group practice that wishes to authorize or instruct the registry to submit quality measures results and numerator and denominator data on the electronic prescribing measure to CMS on their behalf.

For group practices who are selected to participate in the 2010 E-Prescribing Incentive Program group practice reporting option and choose to do so through EHR-based reporting of the electronic prescribing measure, once the EHR is programmed by the vendor to allow data submission to CMS, the burden to the group practice associated with submission of data on the electronic prescribing measure should be minimal.

In addition to the burden associated with group practices reporting the electronic prescribing measure, group practices would also be required to self-nominate in order to participate in the 2010 E-Prescribing Incentive Program under the group practice reporting option. Since we propose to limit participation in the E-Prescribing Incentive Program group practice reporting option to those group practices selected to participate in the PQRI group practice reporting option, there would not be a separate group practice self-nomination process for the E-Prescribing Incentive Program and, thus, no additional burden.

We invite comments on this burden analysis, including the underlying assumptions used in developing our burden estimates.

IV. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

V. Regulatory Impact Analysis

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993, as further amended), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Order 12866 (as amended by Executive Order 13258) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). We estimate, as discussed below in this section, that the PFS provisions included in this proposed rule will redistribute more than $100 million in 1 year. Therefore, we estimate that this rulemaking is ''economically significant'' as measured by the $100 million threshold, and hence also a major rule under the Congressional Review Act. Accordingly, we have prepared a Regulatory Impact Analysis that to the best of our ability presents the costs and benefits of the rulemaking.

The RFA requires agencies to analyze options for regulatory relief of small businesses and other small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, we estimate that most hospitals and most other providers are small entities as that term is used in the RFA (including small businesses, nonprofit organizations, and small governmental jurisdictions). The great majority of hospitals and most other health care providers and suppliers are small entities, either by being nonprofit organizations or by meeting the Small Business Administration (SBA) definition of a small business (having revenues of $7 million to $34.5 million in any 1 year) (for details *see* the SBA's Web site at *http://sba.gov/idc/groups/public/documents/sba_homepage/serv_sstd_tablepdf.pdf* (refer to the 620000 series).

Individuals and States are not included in the definition of a small entity. The RFA requires that we analyze regulatory options for small businesses and other entities. We prepare a regulatory flexibility analysis unless we certify that a rule would not have a significant economic impact on a substantial number of small entities. The analysis must include a justification concerning the reason action is being taken, the kinds and number of small entities the rule affects, and an explanation of any meaningful options that achieve the objectives with less significant adverse economic impact on the small entities.

For purposes of the RFA, physicians, NPPs, and suppliers including IDTFs are considered small businesses if they generate revenues of $7 million or less based on SBA size standards. Approximately 95 percent of physicians are considered to be small entities. There are over 1 million physicians, other practitioners, and medical suppliers that receive Medicare payment under the PFS.

For purposes of the RFA approximately 85 percent of suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) are considered small businesses according to the SBA size standards. We estimate that approximately 66,000 entities bill Medicare for DMEPOS each year. Total annual estimated Medicare revenues for DMEPOS suppliers are approximately $10.8 billion in 2007 for which $8.3 billion was for fee-for-service (FFS) and $2.5 billion was for managed care.

For purposes of the RFA, approximately 80 percent of clinical diagnostic laboratories are considered small businesses according to the SBA size standards.

Ambulance providers and suppliers for purposes of the RFA are also considered to be small entities.

In addition, most ESRD facilities are considered small entities for purposes of the RFA, either based on nonprofit status or by having revenues of $7 million to $34.5 million or less in any year. We note that a considerable number of ESRD facilities are owned and operated by large dialysis organizations (LDOs) or regional chains, which would have total revenues more than $34.5 million in any year if revenues from all locations are combined. However, the claims data we use to estimate payments for this RFA and RIA does not identify which dialysis facilities are parts of an LDO, regional chain, or other type of ownership. Each individual dialysis facility has its own provider number and bills Medicare using this number. Therefore, we consider each ESRD to be a small entity for purposes of the RFA. We consider a substantial number of entities to be significantly affected if the proposed rule has an annual average impact on small entities of 3 to 5 percent or more. The majority of ESRD facilities will experience impacts of less than 2 percent of total revenues. There are 929 nonprofit ESRD facilities with a combined increase of 0.9 percent in overall payments relative to current overall payments. We note that although the overall effect of the wage index changes is budget neutral, there are increases and decreases based on the location of individual facilities. The analysis and discussion provided in this section and elsewhere in this proposed rule complies with the RFA requirements.

Because we acknowledge that many of the affected entities are small entities, the analysis discussed throughout the preamble of this proposed rule constitutes our regulatory flexibility analysis for the remaining provisions and addresses comments received on these issues.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis, if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. Any such regulatory impact analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. We do not believe this proposed rule has impact on significant operations of a substantial number of small rural hospitals because most dialysis facilities are freestanding. While there are 177 rural hospital-based dialysis facilities, we do not know how many of them are based at hospitals with fewer than 100 beds. However, overall, the 177 rural hospital-based dialysis facilities will experience an estimated 1.1 percent increase in payments. As a result, this rule will not have a significant impact on small rural hospitals. Therefore, the Secretary has determined that this proposed rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2009, that threshold is approximately $133 million. This proposed rule will not mandate any requirements for State, local, or Tribal governments. Medicare beneficiaries are considered to be part of the private sector and as a result a more detailed discussion is presented on the Impact of Beneficiaries in section V. of this regulatory impact analysis.

We have examined this proposed rule in accordance with Executive Order 13132 and have determined that this regulation would not have any substantial direct effect on State or local governments, preempt States, or otherwise have a Federalism implication.

We have prepared the following analysis, which together with the information provided in the rest of this preamble, meets all assessment requirements. The analysis explains the rationale for and purposes of this proposed rule; details the costs and benefits of the rule; analyzes alternatives; and presents the measures we will use to minimize the burden on small entities. As indicated elsewhere in this rule, we are implementing a variety of changes to our regulations, payments, or payment policies to ensure that our payment systems reflect changes in medical practice and the relative value of services. We provide information for each of the policy changes in the relevant sections of this proposed rule. We are unaware of any relevant Federal rules that duplicate, overlap, or conflict with this proposed rule. The relevant sections of this rule contain a description of significant alternatives if applicable.

A. RVU Impacts

1. Resource-Based Work PE and MP RVUs

Section 1848(c)(2)(B)(ii) of the Act requires that increases or decreases in RVUs may not cause the amount of expenditures for the year to differ by more than $20 million from what expenditures would have been in the absence of these changes. If this threshold is exceeded, we make adjustments to preserve BN.

Our estimates of changes in Medicare revenues for PFS services compare payment rates for CY 2009 with proposed payment rates for CY 2010 using CY 2008 Medicare utilization for all years. To the extent that there are year-to-year changes in the volume and mix of services provided by physicians, the actual impact on total Medicare revenues will be different than those shown in Table 39. The payment impacts reflect averages for each specialty based on Medicare utilization. The payment impact for an individual physician would be different from the average, based on the mix of services the physician provides. The average change in total revenues would be less than the impact displayed here because physicians furnish services to both Medicare and non-Medicare patients and specialties may receive substantial Medicare revenues for services that are not paid under the PFS. For instance, independent laboratories receive approximately 80 percent of their Medicare revenues from clinical laboratory services that are not paid under the PFS.

Table 39 shows only the payment impact on PFS services. The following is an explanation of the information represented in Table 39

- *Specialty:* The physician specialty or type of practitioner/supplier.
- *Allowed charges:* Allowed charges are the Medicare Fee Schedule amounts for covered services and include coinsurance and deductibles (which are the financial responsibility of the beneficiary.) These amounts have been summed across all services furnished by physicians, practitioners, or suppliers within a specialty to arrive at the total allowed charges for the specialty.
- Impact of Proposed Work RVU changes for the CY 2010 PFS.
- Impact of Proposed PE RVU changes for the CY 2010 PFS.
- Impact of Proposed MP RVU changes for the CY 2010 PFS.
- Combined Impact of all Proposed Changes. The impact shown is a combined impact that incorporates all proposed changes to Work RVUs, PE RVUs, and MP RVUs, prior to the

application of the CY 2010 negative PFS CF update under the current statute.

TABLE 39—CY 2010 TOTAL ALLOWED CHARGE IMPACT FOR WORK, PRACTICE EXPENSE, AND MALPRACTICE CHANGES *

	Specialty	Allowed charges (mil)	Impact of work RVU changes (%)	Impact of PE RVU changes** (%)	Impact of MP RVU changes (%)	Combined impact (%)
	(A)	(B)		(C)	(D)	(E)
1	TOTAL	$77,744	0	1	0	1
2	ALLERGY/IMMUNOLOGY	171	0	0	−2	−3
3	ANESTHESIOLOGY	1,713	0	5	1	6
4	CARDIAC SURGERY	371	−1	−1	3	−2
5	CARDIOLOGY	7,179	0	−10	−1	−11
6	COLON AND RECTAL SURGERY	129	−1	5	1	5
7	CRITICAL CARE	221	0	3	1	3
8	DERMATOLOGY	2,504	0	2	0	3
9	EMERGENCY MEDICINE	2,395	0	2	0	2
10	ENDOCRINOLOGY	370	−1	3	0	3
11	FAMILY PRACTICE	5,055	2	5	1	8
12	GASTROENTEROLOGY	1,779	−1	1	0	0
13	GENERAL PRACTICE	719	1	5	0	6
14	GENERAL SURGERY	2,213	−1	4	1	4
15	GERIATRICS	167	1	6	1	8
16	HAND SURGERY	89	−1	4	0	3
17	HEMATOLOGY/ONCOLOGY	1,888	0	−5	−1	−6
18	INFECTIOUS DISEASE	549	−1	4	1	3
19	INTERNAL MEDICINE	10,061	1	4	1	6
20	INTERVENTIONAL PAIN MANAGEMENT	352	−1	7	0	6
21	INTERVENTIONAL RADIOLOGY	227	0	−10	0	−10
22	NEPHROLOGY	1,789	0	1	1	2
23	NEUROLOGY	1,417	−2	6	0	3
24	NEUROSURGERY	586	−1	3	1	2
25	NUCLEAR MEDICINE	72	0	−12	−2	−13
26	OBSTETRICS/GYNECOLOGY	615	0	1	0	1
27	OPHTHALMOLOGY	4,736	0	11	0	11
28	ORTHOPEDIC SURGERY	3,257	0	4	0	3
29	OTOLARNGOLOGY	926	−1	3	−1	1
30	PATHOLOGY	985	0	−1	0	0
31	PEDIATRICS	64	1	4	0	4
32	PHYSICAL MEDICINE	816	0	7	0	7
33	PLASTIC SURGERY	278	−1	5	1	5
34	PSYCHIATRY	1,071	0	2	1	3
35	PULMONARY DISEASE	1,753	−1	3	1	3
36	RADIATION ONCOLOGY	1,799	0	−17	−1	−19
37	RADIOLOGY	5,254	0	−10	−1	−11
38	RHEUMATOLOGY	494	0	0	0	−1
39	THORACIC SURGERY	389	−1	0	3	2
40	UROLOGY	1,989	0	−6	0	−7
41	VASCULAR SURGERY	685	−1	−1	0	−1
42	AUDIOLOGIST	35	0	−4	−7	−10
43	CHIROPRACTOR***	700	0	4	1	5
44	CLINICAL PSYCHOLOGIST	533	0	−7	0	−7
45	CLINICAL SOCIAL WORKER	353	0	−6	1	−6
46	NURSE ANESTHETIST	772	0	2	0	2
47	NURSE PRACTITIONER	1,004	1	5	1	7
48	OPTOMETRY	834	1	11	0	12
49	ORAL/MAXILLOFACIAL SURGERY	35	−1	3	−1	1
50	PHYSICAL/OCCUPATIONAL THERAPY	1,857	0	10	0	10
51	PHYSICIAN ASSISTANT	749	0	4	0	5
52	PODIATRY	1,656	1	7	−1	6
53	DIAGNOSTIC TESTING FACILITY	1,044	0	−19	−5	−24
54	INDEPENDENT LABORATORY	960	0	−4	−1	−5
55	PORTABLE X-RAY SUPPLIER	85	0	−8	−2	−11

* Does not include the impact of the current law CY 2010 negative update. Rows may not sum to total due to rounding.

** Note: The law caps the MFS imaging payment amount at the comparable payment amount in the hospital outpatient payment system (OPPS cap). In the absence of the negative current law CY 2010 MFS update, the proposed PE change to the equipment utilization rate for expensive equipment from 50 percent to 90 percent would increase expenditures by approximately 1 percent due to a loss of savings from the OPPS cap.

*** Does not reflect the BN reduction in payments resulting from the chiropractic demonstration.

2. Resource-Based Work, PE, and MP RVUs Impacts

a. Work RVU Impacts

The work RVU impacts are almost entirely attributable to the proposed changes for consultation services. As described earlier in this proposed rule, we are proposing to no longer recognize the BILLING CODEs for consultation services so we are budget neutrally eliminating the use of all consultation codes (except for telehealth) and have allocated the work RVUs that were allotted to these services to the work RVUs for new and established office visit services, initial hospital visits, and initial nursing facility visits to reflect this change.

b. PE RVUs Impacts

The PE RVU impacts are primarily attributable to the proposed incorporation of PE data from the Physician Practice Information Survey (PPIS). For a discussion of the use of this updated survey data, see section II.A.2. of this proposed rule.

For two specialties, IDTFs and Radiation Oncology, the impact of our proposed change in the utilization rate for expensive equipment is also significant. We estimate that for these two specialties, the utilization rate change will result in impacts of −2 percent and −5 percent (respectively). These impacts are included in the −19 percent and −17 percent PE RVU impacts shown in Table 39 for these specialties. After taking into account the OPPS payment cap, the change in the utilization rate for expensive equipment does not substantially reduce overall payments for other specialties.

Our proposals on consultation codes (*see* section II.E.4. of this proposed rule) and dominant specialty (*see* section II.C.2. of this proposed rule) do not have a significant impact on PE payments to specialties.

c. Malpractice RVU Impacts

The PE RVU impacts are attributable to the changes proposed for the Five-Year Review of MP RVUs described earlier in this proposed rule. Of particular note are the impacts on the specialties of Audiology (−7 percent), and IDTFs (−5 percent). These impacts are primarily driven by the expansion of the MP premium data collection and the proposed changes to the methodology for TC services.

d. Combined Impact

Column E of Table 39 displays the proposed combined impact of all RVU changes by specialty. These changes range from increases of +12 percent for optometry to decreases of −24 percent for IDTFs. The effect of our proposals on primary care specialties such as General Practice, Family Practice, Internal Medicine, and Geriatrics are positive with increases ranging from +6 percent to +8 percent. Again, these impacts are prior to the application of the negative CY 2010 CF update under the current statute.

Table 40 shows the estimated impact on total payments for selected high-volume procedures of all of the changes discussed previously, including the effect of the CY 2010 negative PFS CF update. We selected these procedures because they are the most commonly furnished by a broad spectrum of physician specialties. There are separate columns that show the change in the facility rates and the nonfacility rates. For an explanation of facility and nonfacility PE, refer to Addendum A of this proposed rule.

TABLE 40—IMPACT OF PROPOSED RULE AND ESTIMATED PHYSICIAN UPDATE ON 2010 PAYMENT FOR SELECTED PROCEDURES

CPT [1]/ HCPCS	MOD	Description	Facility			Non-facility		
			2009	2010 [2]	Percent change	2009	2010 [2]	Percent change
11721		Debride nail, 6 or more	$27.77	$19.82	−29	$40.39	32.29	−20
17000		Destruct premalg lesion	48.69	40.50	−17	69.97	57.21	−18
27130		Total hip arthroplasty	1,359.71	1,113.00	−18	NA	NA	NA
27244		Treat thigh fracture	1,144.39	944.21	−17	NA	NA	NA
27447		Total knee arthroplasty	1,456.37	1,187.76	−18	NA	NA	NA
33533		CABG, arterial, single	1,892.05	1,524.78	−19	NA	NA	NA
35301		Rechanneling of artery	1,067.93	879.63	−18	NA	NA	NA
43239		Upper GI endoscopy, biopsy	165.55	130.27	−21	323.16	243.84	−25
66821		After cataract laser surgery	251.38	225.15	−10	266.53	237.89	−11
66984		Cataract surg w/iol, 1 stage	638.74	568.96	−11	NA	NA	NA
67210		Treatment of retinal lesion	561.56	502.12	−11	580.67	517.13	−11
71010		Chest x-ray	NA	NA	NA	23.80	16.14	−32
71010	26	Chest x-ray	9.02	6.80	−25	9.02	6.80	−25
77056		Mammogram, both breasts	NA	NA	NA	107.48	80.15	−25
77056	26	Mammogram, both breasts	44.36	33.98	−23	44.36	33.98	−23
77057		Mammogram, screening	NA	NA	NA	81.51	57.49	−29
77057	26	Mammogram, screening	35.71	27.47	−23	35.71	27.47	−23
77427		Radiation tx management, x5	188.27	155.48	−17	188.27	155.48	−17
78465	26	Heart image (3d), multiple	78.99	56.92	−28	78.99	56.92	−28
88305	26	Tissue exam by pathologist	37.15	29.45	−21	37.15	29.45	−21
90801		Psy dx interview	128.04	96.01	−25	152.92	118.95	−22
90862		Medication management	45.08	35.40	−21	55.18	45.31	−18
90935		Hemodialysis, one evaluation	66.36	54.09	−18	NA	NA	NA
92012		Eye exam established pat	45.80	41.35	−10	70.69	62.87	−11
92014		Eye exam & treatment	70.33	62.59	−11	103.15	91.76	−11
92980		Insert intracoronary stent	847.93	587.08	−31	NA	NA	NA
93000		Electrocardiogram, complete	20.92	13.03	−38	20.92	13.03	−38
93010		Electrocardiogram report	9.02	6.80	−25	9.02	6.80	−25
93015		Cardiovascular stress test	100.27	61.74	−38	100.27	61.74	−38
93307	26	Tte w/o doppler, complete	49.77	35.97	−28	49.77	35.97	−28
93510	26	Left heart catheterization	248.86	169.36	−32	248.86	169.36	−32
98941		Chiropractic manipulation	30.30	24.36	−20	33.90	28.04	−17

TABLE 40—IMPACT OF PROPOSED RULE AND ESTIMATED PHYSICIAN UPDATE ON 2010 PAYMENT FOR SELECTED PROCEDURES—Continued

CPT[1]/ HCPCS	MOD	Description	Facility			Non-facility		
			2009	2010[2]	Percent change	2009	2010[2]	Percent change
99203		Office/outpatient visit, new	68.17	60.04	−12	91.97	81.00	−12
99213		Office/outpatient visit, est	44.72	39.93	−11	61.31	54.09	−12
99214		Office/outpatient visit, est	69.25	61.17	−12	92.33	80.15	−13
99222		Initial hospital care	122.63	106.77	−13	NA	NA	NA
99223		Initial hospital care	180.33	156.05	−13	NA	NA	NA
99231		Subsequent hospital care	37.15	30.87	−17	NA	NA	NA
99232		Subsequent hospital care	66.72	56.07	−16	NA	NA	NA
99233		Subsequent hospital care	95.58	80.43	−16	NA	NA	NA
99236		Observ/hosp same date	207.38	170.77	−18	NA	NA	NA
99239		Hospital discharge day	96.30	81.85	−15	NA	NA	NA
99283		Emergency dept visit	61.31	49.84	−19	NA	NA	NA
99284		Emergency dept visit	114.33	92.89	−19	NA	NA	NA
99291		Critical care, first hour	212.07	173.89	−18	253.91	206.74	−19
99292		Critical care, add Æl 30 min	106.04	86.94	−18	114.69	93.74	−18
99348		Home visit, est patient	NA	NA	NA	79.35	65.42	−18
99350		Home visit, est patient	NA	NA	NA	160.86	137.92	−14
G0008		Admin influenza virus vac	NA	NA	NA	20.92	16.99	−19

[1] CPT codes and descriptions are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] Based upon projected −21.5 reduction in the conversion factor.

B. Geographic Practice Cost Indices (GPCIs)

As discussed in section II.C. of this proposed rule, the application of the 1.000 work GPCI floor, as extended by section 134(a) of the MIPPA, expires effective January 1, 2010. As a result, 54 (out of 89) PFS localities will receive a decrease in their work GPCI. Puerto Rico receives the largest decrease (−9.6 percent), followed by South Dakota (−5.8 percent), North Dakota (−5.3 percent), Rest of Missouri (−5.1 percent), and Montana (−5.0 percent).

C. Medicare Telehealth Services

In section II.D. of this proposed rule, we are proposing to add individual health behavior and assessment services (as described by HCPCS codes 96150 through 96152) to the list of telehealth services. We are also proposing to revise § 410.78 to specify that the G-codes for follow-up inpatient telehealth consultations (as described by HCPCS codes G0406 through G0408) include follow-up telehealth consultations furnished to beneficiaries in hospitals and skilled nursing facilities.

The total annual Medicare payment amount for telehealth services (including the originating site facility fee) is approximately $2 million. Previous additions to the list of telehealth services have not resulted in a significant increase in Medicare program expenditures. While we believe that these proposals will provide more beneficiaries with access to these services, we do not anticipate that these proposed changes will have a significant budgetary impact on the Medicare program.

D. MIPPA Provisions

1. Section 102: Elimination of Discriminatory Copayment Rates for Medicare Outpatient Psychiatric Services

This section of the MIPPA will have a positive impact on Medicare patients because coinsurance payment percentages for outpatient mental health services will be gradually reduced from January 1, 2010 through January 1, 2014. At the conclusion of this 5-year period, Medicare patients will pay the same coinsurance payment percentage for outpatient mental health services as they currently pay for other health services under the Medicare Part B program.

Since the inception of the Medicare Part B program, Medicare patients have been required to pay for a greater percentage of the cost of outpatient mental health treatment services than for other health services because of the Medicare payment limitation (the outpatient mental health treatment limitation). While a dollar cap that previously applied to mental health services was eliminated January 1, 1991, the statute maintained the 62½ percent limitation on the recognition of incurred expenses. This limitation of 62½ percent reduces the program's payment for mental health services to 50 percent, leaving a Medicare patient responsible for paying the other half of these expenses through coinsurance. The 62½ percent limitation will remain in effect until December 31, 2009.

During the transition, the Medicare Part B program will incur increased expenditures as Medicare patients pay less out-of-pocket for outpatient mental health services until, in 2014, patients will pay only the deductible (if applicable) and 20 percent coinsurance. Section 102 of the MIPPA will shift cost-sharing for mental health services from Medicare patients to the program. This provision will result in a cost impact, to the Medicare program, of approximately $100 million for CY 2010. As section 102 of the MIPPA is implemented, the impact of the changes to the coinsurance payment percentages (that is, recognized incurred expenses) for Medicare patients and the program is as shown in Table 41.

TABLE 41—IMPACT OF THE CHANGES TO THE COINSURANCE PAYMENT PERCENTAGES UNDER SECTION 102 OF THE MIPPA

CY 2009 and prior calendar years—Medicare limitation, 62.50 percent of recognized incurred expenses.
Medicare Patient pays—50%.
Medicare Part B pays—50%.
CY 2010 and CY 2011—Medicare limitation, 68.75 percent of recognized incurred expenses.
Medicare Patient pays—45%.
Medicare Part B pays—55%.
CY 2012—Medicare limitation, 75 percent of recognized incurred expenses.
Medicare Patient pays—40%.
Medicare Part B pays—60%.
CY 2014—No limitation, 100.00 percent of recognized incurred expenses.

TABLE 41—IMPACT OF THE CHANGES TO THE COINSURANCE PAYMENT PERCENTAGES UNDER SECTION 102 OF THE MIPPA—Continued

Medicare Patient pays—20%. Medicare Part B pays—80%.

2. Section 131 b: Physician Payment, Efficiency, and Quality Improvements—Physician Quality Reporting Initiative (PQRI)

As discussed in section II.G.2. of this proposed rule, the proposed 2010 PQRI measures satisfy the requirement of section 1848(k)(2)(D) of the Act that the Secretary shall ensure that eligible professionals have the opportunity to provide input during the development, endorsement, or selection of measures applicable to services they furnish. As discussed in section II.G.2.d. of this proposed rule, we also propose to offer options in 2010 for reporting the proposed 2010 PQRI measures via submission of data to a clinical registry, options for reporting some of the proposed 2010 PQRI measures via submission of data extracted from an EHR, options for reporting on measures groups rather than individual measures, and options for group practices to be treated as satisfactorily submitting quality data under the PQRI.

Although there may be some cost incurred for maintaining the measures used in the PQRI and their associated code sets, and for expanding an existing clinical data warehouse to accommodate registry-based reporting and EHR-based reporting for the PQRI, we do not anticipate a significant cost impact on the Medicare program.

Participation in the PQRI by eligible professionals is voluntary and eligible professionals and group practices may have different processes for integrating the PQRI into their practices' work flows. Therefore, it is not possible to estimate with any degree of accuracy the impact of the PQRI on providers.

With respect to satisfactory submission of data on quality measures by eligible professionals, one factor that influences the cost to eligible professionals is the time and effort associated with eligible professionals identifying applicable PQRI quality measures for which they can report the necessary information. We have no way to accurately quantify the burden because it would vary with each eligible professional by the number of measures applicable to the eligible professional, the eligible professional's familiarity and understanding of the PQRI, and experience with participating in the PQRI. In addition, eligible professionals may employ different methods for incorporating the use of quality data codes into the office work flows. Therefore, we will continue to assign 3 hours as the amount of time needed for eligible professionals to review the PQRI quality measures, identify the applicable measures for which they can report the necessary information, and incorporate the use of quality data codes into the office work flows. Information from the Physician Voluntary Reporting Program (PVRP), which was a predecessor to the PQRI, indicated an average labor cost of approximately $50 per hour. To account for salary increases over time, we will use an average practice labor cost of $55 per hour for our estimates based on an assumption of an average annual increase of approximately 3 percent. Thus, we continue to estimate the cost for an eligible professional to review the PQRI quality measures, identify the applicable measures for which they can report the necessary information, and incorporate the use of quality data codes into the office work flows to be approximately $165 per eligible professional ($55 per hour × 3 hours).

For claims-based PQRI reporting, one factor in the cost to eligible professionals is the time and effort associated with gathering the required information, selecting the appropriate quality data codes, and including the appropriate quality data codes on the Medicare Part B claims an eligible professional submits for payment. Information from the PVRP estimates the cost to physicians to perform all the steps necessary to report 1 quality measure ranges from $0.21 in labor time to about $10.06 in labor time for more complicated cases and/or measures. For the median practice, the cost was about $0.90 in labor time per measure. Eligible professionals generally would be required to report at least 3 measures to satisfactorily report PQRI quality measures data. Therefore, for purposes of this impact analysis we will assume that eligible professionals participating in the 2010 PQRI will report an average of 3 measures each.

The cost of implementing claims-based reporting of PQRI quality measures data also varies with the volume of claims on which quality data is reported. Since we propose to require eligible professionals to report at least one of their selected measures for at least 15 Medicare Part B FFS patients in order to satisfactorily report, then, for this burden analysis, we will assume that for each measure, the eligible professional reports the quality data codes on 15 cases. The actual number of cases on which an eligible professional would be required to report quality measures data will vary, however, with the eligible professional's patient population and the types of measures on which the eligible professional chooses to report (each measure's specifications includes a required reporting frequency).

Based on the assumptions discussed above, we estimate the total annual cost per eligible professional associated with claims-based reporting to range from $174.45 [($0.21 per measure × 3 measures × 15 cases per measure) + $165] to $617.70 [($10.06 per measure × 3 measures × 15 cases per measure) + $165].

For registry-based reporting, eligible professionals must generally incur a cost to submit data to registries. Estimated fees for using a qualified registry range from a nominal charge for an eligible professional to use the registry to costing eligible professionals several thousand dollars. Thus, we conservatively estimate the cost incurred by an eligible professional to participate in PQRI via registry-based reporting to be approximately $500 per eligible professional.

In addition, an eligible professional who chooses to submit PQRI quality measures results and numerator and denominator data on quality measures through a registry more than likely is already reporting data to the registry. Little, if any, additional data would need to be reported to the registry for purposes of participation in the 2010 PQRI. Therefore, there should be little additional cost to the eligible professional associated with submitting data to the registry.

Registries interested in submitting quality measures results and numerator and denominator data on quality measures to CMS on their participants' behalf would need to complete a self-nomination process in order to be considered ''qualified'' to submit on behalf of eligible professionals. We estimate the registry self-nomination process to cost approximately $500 per registry ($50 per hour × 10 hours per registry). This cost estimate includes the cost of submitting the self-nomination letter to CMS and completing the CMS vetting process. Our estimate of a $50 per hour average labor cost for registries is based on the assumption that registry staff include IT professionals whose average hourly rates range from $36 to $84 per hour depending on experience, with an average rate of nearly $50 per hour for a mid-level programmer.

The cost to the registry associated with the registry-based reporting requirements of this voluntary reporting initiative is the time and effort

associated with the registry calculating quality measure results from the data submitted to the registry by its participants and submitting the quality measures results and numerator and denominator data on quality measures to CMS on behalf of their participants. The time needed for a registry to review the quality measures and other information, calculate the measures results, and submit the measures results and numerator and denominator data on the quality measures on their participants behalf is expected to vary along with the number of eligible professionals reporting data to the registry and the number of applicable measures. However, we believe that registries already perform many of these activities for their participants.

For EHR-based reporting, an eligible professional generally would incur a cost associated with purchasing an EHR product. We estimate that it costs between $1,500 to over $5,000 to purchase an EHR product. Therefore, we conservatively estimate the average total cost to an eligible professional to be approximately $2,750.

An EHR vendor interested in having their product(s) be used by eligible professionals to submit quality measures results and numerator and denominator data on quality measures to CMS were required to complete a self-nomination process in order for the vendor's product(s) to be considered ''qualified'' for 2010. Therefore, one factor in the cost to EHR vendors is the cost associated with completing the self-nomination process in order for the vendor's EHR product(s) to be considered ''qualified.'' Similar to the estimated cost to the registry associated with the registry self-nomination process, the estimated cost for an EHR vendor to complete the self-nomination process, including the vetting process with CMS officials, is conservatively estimated to be $500 ($50 per hour × 10 hours per EHR vendor). Our estimate of a $50 per hour average labor cost for registries is based on the assumption that registry staff include IT professionals whose average hourly rates range from $36 to $84 per hour depending on experience, with an average rate of nearly $50 per hour for a mid-level programmer.

Another factor in the cost to EHR vendors is the time and effort associated with the EHR vendor programming its EHR product(s) to extract the clinical data that the eligible professional needs to submit to CMS for purposes of reporting 2010 PQRI quality measures. The cost associated with the time and effort needed for an EHR vendor to review the quality measures and other information and program each qualified EHR product to enable eligible professionals to submit PQRI quality measures data to the CMS-designated clinical warehouse will be dependent on the EHR vendor's familiarity with PQRI, the vendor's system capabilities, as well as the vendor's programming capabilities. Some vendors already have these necessary capabilities and for such vendors, we estimate the total cost to be approximately $2,000 ($50 per hour × 40 hours per vendor). However, given the variability in the capabilities of the vendors, we believe a more conservative estimate for those vendors with minimal experience would be approximately $10,000 per vendor ($50 per hour × 200 hours per EHR vendor).

With respect to the proposed process for group practices to be treated as satisfactorily submitting quality measures data under the 2010 PQRI discussed in section II.G.2.g. of this proposed rule, group practices interested in participating in the 2010 PQRI through the group practice reporting option would need to complete a self-nomination process similar to the self-nomination process required of registries and EHR vendors. We estimate that the group practice staff involved in the group practice self-nomination process have an average labor cost of $55 per hour. Therefore, assuming the total burden hours per group practice associated with the group practice self-nomination process is 4 hours, we estimate the total cost to a group practice associated with the group practice self-nomination process to be approximately $220 ($55 per hour × 4 hours per group practice).

The cost associated with the group practice reporting requirements of this voluntary reporting initiative is the time and effort associated with the group practice submitting the quality measures data. For physician group practices, this would be the time associated with the physician group completing the proposed data collection tool. The information collection components of this data collection tool have been reviewed by OMB and are currently approved under OMB control number 0938–0941, with an expiration date of December 31, 2011. Based on cost estimates for the Physician Group Practice (PGP) demonstration, which uses the same data submission methods as what we have proposed, we estimate the cost associated with a physician group completing the data collection tool would be approximately 79 hours per physician group. Therefore, we estimate the total annual burden hours per physician group would be approximately 83 hours (4 hours for self-nomination + 79 hours for data submission). Based on an average labor cost of $55 per physician group, we estimate the cost per physician group associated with participating in the proposed PQRI group practice reporting option would be $4,565 ($55 per hour × 83 hours per group practice).

3. Section 131(c): Physician Resource Use Measurement and Reporting Program

As discussed in section II.G.3. of this proposed rule, section 131(c) of the MIPPA amends section 1848 of the Act by adding subsection (n), which requires the Secretary to establish and implement by January 1, 2009, a Physician Feedback Program using Medicare claims data and other data to provide confidential feedback reports to physicians (and as determined appropriate by the Secretary, to groups of physicians) that measure the resources involved in furnishing care to Medicare beneficiaries. If determined appropriate by the Secretary, the Secretary may also include information on quality of care furnished to Medicare beneficiaries by the physician (or group of physicians) in the reports. We anticipate the impact of this section to be negligible for the work completed in the phased pilot physician feedback program to date.

4. Section 132: Incentives for Electronic Prescribing (E-Prescribing)—The E-Prescribing Incentive Program

Section II.G.5. of this proposed rule describes the proposed 2010 E-Prescribing Incentive Program. To be considered a successful e-prescriber in 2010, an eligible professional would need to meet the requirements proposed in section II.G.5.c. of this proposed rule.

We anticipate that the cost impact of the E-Prescribing Incentive Program on the Medicare program would be the cost incurred for maintaining the electronic prescribing measure and its associated code set, and for expanding an existing clinical data warehouse to accommodate registry-based reporting and, potentially, EHR-based reporting for the electronic prescribing measure. We, however, do not anticipate a significant cost impact on the Medicare program since much of this infrastructure had already been established for the PQRI.

Participation in the E-Prescribing Incentive Program by eligible professionals is voluntary and eligible professionals may have different processes for integrating the E-Prescribing Incentive Program into their practices' work flows. Therefore, it is not possible to estimate with any degree of accuracy the impact of the E-

Prescribing Incentive Program on eligible professionals. Similar to claims-based reporting for PQRI, one factor in the cost to eligible professionals, for those eligible professionals who choose to report the electronic prescribing measure through claims, is the time and effort associated with eligible professionals determining whether the quality measure is applicable to them, gathering the required information, selecting the appropriate quality data codes, and including the appropriate quality data codes on the claims they submit for payment. Since the E-Prescribing Incentive Program consists of only 1 quality measure, we will assign 1 hour as the amount of time needed for eligible professionals to review the e-prescribing measure and incorporate the use of quality data codes into their office work flows. At an average cost of approximately $55 per hour, we estimate the total cost to eligible professionals for reviewing the e-prescribing measure and incorporating the use of quality data codes into the office work flows to be approximately $55 ($55 per hour × 1 hour).

Another factor in the cost to eligible professionals is the time and effort associated with gathering the required information, selecting the appropriate quality data codes, and including the appropriate quality data codes on the claims an eligible professional submits for payment. Information from the PVRP estimates the cost to physicians to perform all of the steps necessary to report 1 quality measure ranges from $0.21 in labor time to about $10.06 in labor time for more complicated cases and/or measures. For the median practice, the cost was about $0.90 in labor time per measure. Therefore, we estimate the costs to eligible professionals to perform all the steps necessary to report the electronic prescribing measure on a claim to be approximately $0.90.

The cost for this requirement will also vary along with the volume of claims on which quality data is reported. Based on our proposal to require an eligible professional to report the G8443 code for the electronic prescribing measure for at least 25 instances, we estimate the total annual estimated cost per eligible professional to report the electronic prescribing measure to be $77.50 [($0.90 per measure × 1 measure × 25 cases per measure) + $55].

Because registry-based reporting of the electronic prescribing measure to CMS would be new for 2010 and participation in this reporting initiative is voluntary, it is impossible to estimate with any degree of accuracy how many eligible professionals will opt to participate in the E-Prescribing Incentive Program through the registry-based reporting mechanism in CY 2010. We do not anticipate, however, any additional cost for eligible professionals to report data to a registry as eligible professionals opting for registry-based reporting would more than likely already be reporting data to the registry. Little, if any, additional data would need to be reported to the registry for purposes of participation in the 2010 E-Prescribing Incentive Program.

One potential cost to some eligible professionals associated with either claims-based reporting or registry-based reporting would be the cost of purchasing and using an e-prescribing system. There are currently many commercial packages available for e-prescribing. One study indicated that a mid-range complete electronic medical record with electronic prescribing functionality costs $2500 per license with an annual fee of $90 per license for quarterly updates of the drug database after setup costs while a standalone prescribing, messaging, and problem list system costs $1200 per physician per year after setup costs. Hardware costs and setup fees substantially add to the final cost of any software package. (Corley, S.T. (2003). ''Electronic prescribing: a review of costs and benefits.'' Topics in Health Information Management 24(1): 29–38.). The cost to an eligible professional of obtaining and utilizing an e-prescribing system varies not only by the commercial software package selected but also by the level at which the professional currently employs information technology in his or her practice and the level of training needed.

Based on our proposal to consider only registries qualified to submit quality measures results and numerator and denominator data on quality measures to CMS on their participants' behalf for the 2010 PQRI to be qualified to submit results and numerator and denominator data on the electronic prescribing measure for the 2010 E-Prescribing Incentive Program, we do not anticipate any cost to the registry associated with becoming a registry qualified to submit the electronic prescribing measure for 2010.

The cost associated with the registry-based reporting requirements of this voluntary reporting initiative for the registry would be the time and effort associated with the registry calculating results for the electronic prescribing measure from the data submitted to the registry by its participants and submitting the quality measures results and numerator and denominator data on the electronic prescribing quality measure to CMS on behalf of their participants. The time needed for a registry to review the electronic prescribing measure and other information, calculate the measure's results, and submit the measure's results and numerator and denominator data on the measure on their participants behalf is expected to vary along with the number of eligible professionals reporting data to whom the measure applies. However, we believe that registries already perform many of these activities for their participants. Since the E-Prescribing Incentive Program consists of only one measure, we believe that the cost associated with the registry reporting the measure's results and numerator and denominator to CMS on behalf of their participants would be minimal.

For EHR-based reporting (if we finalize an EHR-based reporting mechanism for the E-Prescribing Incentive Program), the eligible professional must review the electronic prescribing measure, extract the necessary clinical data from his or her EHR, and submit the necessary data to the CMS-designated clinical data warehouse. Because this manner of reporting quality data to CMS would be new for 2010 and participation in this reporting initiative is voluntary, it is impossible to estimate with any degree of accuracy how many eligible professionals will opt to participate in the E-Prescribing Incentive Program through the EHR-based reporting mechanism in CY 2010. The cost associated with an eligible professional reviewing the electronic prescribing measure and other information and determining whether the measure is applicable to his or her patients and the services he or she furnishes to them is expected to be similar for EHR-based reporting and claims-based reporting (that is, $55 at a rate of $55 per hour). Once the EHR is programmed by the vendor to allow data submission to CMS, the cost to the eligible professional associated with the time and effort to submit data on the electronic prescribing measure should be minimal.

Based on our proposal to consider only EHR products qualified for the 2010 PQRI to be qualified to submit results and numerator and denominator data on the electronic prescribing measure for the 2010 E-Prescribing Incentive Program, there would be no need for EHR vendors to undergo a separate self-nomination process for the E-Prescribing Incentive Program and therefore, no additional cost associated with the self-nomination process.

The cost to the EHR vendor associated with the EHR-based reporting requirements of this voluntary reporting initiative is the time and effort associated with the EHR vendor programming its EHR product(s) to extract the clinical data that the eligible professional needs to submit to CMS for purposes of reporting the 2010 electronic prescribing measure. The time needed for an EHR vendor to review the measure and other information and program each qualified EHR product to enable eligible professionals to submit data on the measure to the CMS-designated clinical data warehouse will be dependent on the EHR vendor's familiarity with the electronic prescribing measure, the vendor's system capabilities, as well as the vendor's programming capabilities. Since only EHR products qualified for the 2010 PQRI would be qualified for the 2010 E-Prescribing Incentive Program and the E-Prescribing Incentive Program consists of only one measure, we believe that any burden associated with the EHR vendor to program its product(s) to enable eligible professionals to submit data on the electronic prescribing measure to the CMS-designated clinical data warehouse would be minimal.

With respect to the proposed process for group practices to be treated as successful e-prescribers under the 2010 E-Prescribing Incentive Program discussed in section II.G.5.e. of this proposed rule, a group practice would be required to report the electronic prescribing measure in at least 2500 instances. Group practices have the same options as individual eligible professionals in terms of the form and manner for reporting the electronic prescribing measure (that is, group practices have the option of reporting the measure through claims, a qualified registry, or a qualified EHR product). The only difference between an individual eligible professional and group practice reporting of the electronic prescribing measure is the number of times a group practice is required to report the electronic prescribing measure. For group practices who are selected to participate in the 2010 E-Prescribing Incentive Program group practice reporting option and choose to do so through claims-based reporting of the electronic prescribing measure, we estimate the total annual estimated cost per group practice to be $2,305 [($0.90 per measure × 1 measure × 2500 cases per measure) + $55].

For group practices who are selected to participate in the 2010 E-Prescribing Incentive Program group practice reporting option and choose to do so through registry-based reporting of the electronic prescribing measure, we do not anticipate any additional burden to report data to a registry as group practices opting for registry-based reporting would more than likely already be reporting data to the registry. Little, if any, additional data would need to be reported to the registry for purposes of participation in the 2010 E-Prescribing Incentive Program. However, group practices would need to authorize or instruct the registry to submit quality measures results and numerator and denominator data on the electronic prescribing measure to CMS on their behalf. We estimate that the time and effort associated with this would be approximately 5 minutes for each group practice that wishes to authorize or instruct the registry to submit quality measures results and numerator and denominator data on the electronic prescribing measure to CMS on their behalf.

For group practices who are selected to participate in the 2010 E-Prescribing Incentive Program group practice reporting option and choose to do so through EHR-based reporting of the electronic prescribing measure, once the EHR is programmed by the vendor to allow data submission to CMS, the burden to the group practice associated with submission of data on the electronic prescribing measure should be minimal.

In addition to the burden associated with group practices reporting the electronic prescribing measure, group practices would also be required to self-nominate in order to participate in the 2010 E-Prescribing Incentive Program under the group practice reporting option. Since we propose to limit participation in the E-Prescribing Incentive Program group practice reporting option to those group practices selected to participate in the PQRI group practice reporting option, there would be no additional burden associated with the group practice self-nomination process for the E-Prescribing Incentive Program.

5. Section 135: Implementation of Accreditation Standards for Suppliers Furnishing the Technical Component (TC) of Advanced Diagnostic Imaging Services.

As discussed in section II.G.6. of this proposed rule, suppliers that provide the TC of advanced diagnostic imaging services will have to be accredited by an approved accreditation organization in order to receive Medicare reimbursement for advanced diagnostic imaging services described in section 1848(b)(4)(B) furnished to beneficiaries. This section of the rule will impact the suppliers that provide the TC of advanced diagnostic imaging services and the organizations that accredit suppliers of such services. Suppliers that provide the TC of advanced diagnostic imaging services will incur costs for becoming accredited. Accreditation organizations will incur costs to accredit suppliers. To estimate the impact on suppliers, we calculate the total cost of accreditation as the sum of accreditation fees and other accreditation costs, and we multiply this cost by the number of providers of care requiring accreditation.

Factors Affecting the Cost Impact

According to CMS' Services Tracking and Reporting System (STARS) database for 2008, there are a total of 1,137,278 physicians, IDTFs, hospitals and others billing Part B for the TC of advanced diagnostic imaging. This total includes both suppliers and providers that furnish items under Medicare Part B as suppliers.

Currently, there are suppliers accredited by one of three of the nationally recognized accreditation. We anticipate that the following accreditation organizations will seek approval from CMS to accredit suppliers that provide the TC of advanced diagnostic imaging services:

- American College of Radiology;
- Intersocietal Accreditation Commission; and
- The Joint Commission.

Accreditation Fees

Fees vary between accreditation organizations and, in general, currently cover all of the following items: Application fee, manuals, initial accreditation fee, onsite surveys or other auditing (generally once every 3 years), and travel, when necessary for survey personnel. Accreditation costs also vary by the size of the supplier seeking accreditation, its number of locations, and the number of services it provides. Because of these factors, it is sometimes difficult to compare fees across accreditation organizations. We obtained information on total accreditation fees from the three accreditation organizations that currently accredit suppliers who provide the TC of advanced diagnostic imaging services. Based on all information we obtained, we estimate accreditation fees for each review cycle will be approximately $ 5,000 for an advanced diagnostic imaging supplier. Because accreditation is for a 3-year period, the estimated average cost per year would be approximately $1,666.

We recognize that becoming accredited may impose a burden on suppliers that provide the TC of advanced diagnostic imaging services, especially small suppliers. We have attempted to minimize that burden. We have implemented the following options to minimize the burden of accreditation on suppliers, including small businesses:

- *Multiple accreditation organizations:* We expect that more than one accrediting organization will apply to become and be designated as an advanced diagnostic imaging accrediting organization. We believe that selection of more than one accreditation organization will introduce competition resulting in reductions in accreditation costs.
- *Required plan for small businesses:* During the application process we will require accreditation organizations to include a plan that details their methodology to reduce accreditation fees and burden for small or specialty suppliers. This will need to include that the accreditation organization's fees are based on the size of the organization.
- *Reasonable quality standards:* The quality standards that will be used to evaluate the services rendered for each imaging modality are industry standards. Many suppliers that provide the TC of advanced diagnostic imaging services already comply with the standards and have incorporated these practices into their daily operations. We have been told that that those suppliers with private insurance contracts must be accredited, thus our requirements would not be duplicative. It is our belief and has been stated by those suppliers already accredited that compliance with the quality standards will result in more efficient and effective business practices and will assist suppliers in reducing overall costs.

Other Accreditation Costs

It is difficult to precisely estimate the costs of preparing for accreditation. We do recognize there is cost to the supplier in order to come into compliance initially and thus prepare for the accreditation survey. This should result in minimal preparation and cost.

Additional Considerations

There are at least two important sources of uncertainty in estimating the impact of accreditation on suppliers that provide the TC of advanced diagnostic imaging services. First, our estimates assume that all current suppliers with positive Medicare payments will seek accreditation. We assume that suppliers who currently receive no Medicare allowed charges will choose not to seek accreditation. It is also possible that many of the suppliers with allowed charges between $1 and $10,000 may decide not to incur the costs of accreditation.

Second, it is unclear what accreditation fees will be in the future. However, we are requiring the accreditation organization to submit their fees that are based on the size of the supplier, or on the amount billed. Our experience with another accreditation program has lead us to believe that the accreditation rates will go up, although minimally, if travel costs continue to rise.

In summary, suppliers of the TC of advanced diagnostic imaging services for which payment is made under the fee schedule established under section 1848(b) of the Act must become accredited by an accreditation organization designated by the Secretary beginning January 1, 2012. In the options we have proposed we have attempted to minimize the burden of accreditation on suppliers, which include approving multiple accreditation organizations that consider the small suppliers. Also, the fact that the surveys will be either performed as a desk review or unannounced deletes the time and cost for the accreditation organization in travel, if required.

6. Section 139: Improvements for Medicare Anesthesia Teaching Programs

As discussed in section II.G.7., this proposed rule would provide for increased payments under the Medicare PFS for certain cases involving teaching anesthesiologists with anesthesia residents or for teaching CRNAs with student nurse anesthetists. This provision of the MIPPA is anticipated to have a minimal budgetary impact.

7. Section 144(a): Payment and Coverage Improvements for Patients With Chronic Obstructive Pulmonary Disease and Other Conditions: Cardiac Rehabilitation Services

Current levels of coverage for CR programs will continue under this rule, and new ICR programs will likely develop and request designation by CMS to receive Medicare payments. Because section 144(a) of the MIPPA requires higher payments for ICR programs than for CR programs, this expansion of coverage will result in greater costs to the Medicare program. The requirements for ICR programs, also required in section 144(a) of the MIPPA, are extensive and will likely limit the number of programs that request designation as ICR programs by CMS. As a result, significantly fewer ICR programs than CR programs will function throughout the country; however, we currently do not know how many ICR programs may request designation.

We believe that the proposed expansion of coverage for ICR programs will enable beneficiaries to take advantage of more focused and rigorous programs that will more quickly lead to improved cardiovascular health. Having the choice of CR and ICR programs, beneficiaries eligible for coverage will be able to determine the best manner in which to achieve improved cardiovascular health, through traditional CR or more rigorous ICR programs. We also expect this proposed expansion of coverage to bring more attention to the importance of cardiac rehabilitation and the extensive benefits these programs provide to beneficiaries. As a result, the number of beneficiaries participating in CR programs may increase. We estimate that the proposed provisions for establishing coverage of cardiac rehabilitation and intensive cardiac rehabilitation programs, as discussed in section II.G.8. of this proposed rule, will have a minimal budgetary impact on the Medicare program.

8. Section 144(a): Payment and Coverage Improvements for Patients With Chronic Obstructive Pulmonary Disease and Other Conditions: Pulmonary Rehabilitation Services

As discussed in section II.G.9. of this proposed rule, the implementation of the Medicare pulmonary rehabilitation program will allow Medicare, for the first time, to provide for payment for exercise and other services as part of a comprehensive treatment plan for beneficiaries with moderate to severe COPD. We believe this program has the potential of not only improving the quality of life for beneficiaries who engage in it, but also reducing Medicare costs in the long range by decreasing the chances of exacerbations and further rehabilitation related to their chronic respiratory disease. We estimate this provision will have a minimal budgetary impact on the Medicare program.

9. Section 152(b): Coverage of Kidney Disease Patient Education Services

The implementation of Medicare coverage of kidney disease patient education services as discussed in section II.G.10. of this proposed rule will allow Medicare to provide for payment for kidney disease education services for beneficiaries with Stage IV chronic kidney disease. We believe this program can help patients achieve better

understanding of their illness, dialysis modality options, and may help delay the need for dialysis. We believe this program has the potential of improving the quality of life for beneficiaries since they will be better equipped to make informed decisions. We estimate a cost to the Medicare program of approximately $10 million for CY 2010, because the statute limits the number of kidney disease education sessions to 6, as a lifetime maximum.

10. Section 153: Renal Dialysis Provisions

A discussion of the impact of section 153 of the MIPPA is addressed in section V.F. of this regulatory impact analysis in conjunction with the other ESRD provisions of this rule.

11. Section 182(b): Revision of Definition of Medically-Accepted Indication for Drugs; Compendia for Determination of Medically-Accepted Indications for Off-Label Uses of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen

We anticipate that the proposals related to the compendia discussed in section II.G.12. of this proposed rule will have a negligible cost to the Medicare program and to the public. The information that is required to be collected and published on the compendia Web sites is information that is already collected in the normal course of business by the compendia publishers, which all have Web sites. The proposed changes will enable CMS to efficiently implement the provisions of section 182(b) of the MIPPA that require transparent evaluative and conflict of interest policies and practices for current and future listed compendia on and after January 1, 2010.

E. Payment for Covered Outpatient Drugs and Biologicals

1. Average Sales Price (ASP) Issues

The proposed changes discussed in section II.F.1. of this proposed rule with respect to payment for covered outpatient drugs and biologicals, are estimated to have no impact on Medicare expenditures as we are not proposing any change to the AMP/WAMP threshold and the proposed change concerning the immunosuppressive drug period of eligibility is a comforming change to reflect the statute.

2. Competitive Acquisition Program (CAP) Issues

As discussed in section II.F.2., this proposed rule contains proposals and seeks comment on certain aspects of the CAP, specifically the frequency of drug payment amount updates, changes to the CAP drug list, the geographic area served by the CAP, CAP drug stock at the physician's office, exclusion of CAP sales from ASP calculations, the annual CAP payment amount update mechanism, and updates to proposals made in the 2009 PFS rule. Our changes and refinements may improve compliance, promote program flexibility, improve the quality, and maintain the availability of services for participating CAP physicians. We anticipate that these changes associated with the CAP will not result in significant additional cost savings or increases relative to the ASP payment system for two reasons. First, in 2006 through 2008, the dollar volume of claims paid under the CAP was small compared to the volume of claims paid under section 1847A of the Act, and although we anticipate that the CAP will continue to grow, we do not anticipate a significant change in the proportion of claims paid under these payment systems. Second, because CAP payment amounts are limited to prices calculated under section 1847A of the Act, we expect payment rates for the two programs to remain very similar.

F. Provisions Related to Payment for Renal Dialysis Services Furnished by End-Stage Renal Disease (ESRD) Facilities

The ESRD-related provisions are discussed in sections II.G.11. and II.I. of this proposed rule. To understand the impact of the changes affecting payments to different categories of ESRD facilities, it is necessary to compare estimated payments under the current year (CY 2009 payments) to estimated payments under the revisions to the composite rate payment system (CY 2010 payments) as discussed in section II.I. of this proposed rule. To estimate the impact among various classes of ESRD facilities, it is imperative that the estimates of current payments and estimates of proposed payments contain similar inputs. Therefore, we simulated payments only for those ESRD facilities that we are able to calculate both current 2009 payments and proposed 2010 payments.

ESRD providers were grouped into the categories based on characteristics provided in the Online Survey and Certification and Reporting (OSCAR) file and the most recent cost report data from the Healthcare Cost Report Information System (HCRIS). We also used the December 2008 update of CY 2008 National Claims History file as a basis for Medicare dialysis treatments and separately billable drugs and biologicals. Since the December 2008 update of the CY 2008 National Claims History File is incomplete, we updated the data. The description of the updates for the separately billable drugs is described in section II.I. of this proposed rule. To update the treatment counts we used the ratio of the June 2008 to the December 2007 updates of the CY 2007 National Claims History File figure for treatments. This was an increase of 11.3 percent. Due to data limitations, we are unable to estimate current and proposed payments for 57 of the 5048 ESRD facilities that bill for ESRD dialysis treatments.

Table 42 shows the impact of this year's proposed changes to CY 2010 payments to hospital-based and independent ESRD facilities. The first column of Table 42 identifies the type of ESRD provider, the second column indicates the number of ESRD facilities for each type, and the third column indicates the number of dialysis treatments.

The fourth column shows the effect of all proposed changes to the ESRD wage index for CY 2010 as it affects the composite rate payments to ESRD facilities. The fourth column compares aggregate ESRD wage adjusted composite rate payments in CY 2010 to aggregate ESRD wage adjusted composite rate payments in CY 2009. In CY 2009, ESRD facilities receive 100 percent of the CBSA wage adjusted composite rate and 0 percent of the MSA wage adjusted composite rate, ending a 4-year transition period in which they had received an increasing percent of payments based on the CBSA wage adjusted composite rate. The overall effect to all ESRD providers in aggregate is zero because the CY 2010 ESRD wage index has been multiplied by a Budget Neutrality adjustment factor to comply with the statutory requirement that any wage index revisions be done in a manner that results in the same aggregate amount of expenditures as would have been made without any changes in the wage index.

The fifth column shows the effect of proposed changes to the ESRD wage index in CY 2010 and the effect of the MIPPA provisions on ESRD facilities. Section 153(a) of the MIPPA amended section 1881(b)(12)(G) of the Act to revise payments to ESRD facilities. Effective January 1, 2010, there is an update of 1 percent to the composite rate component of the payment system.

The sixth column shows the overall effect of the proposed changes in composite rate payments to ESRD providers including the drug add-on. The overall effect is measured as the difference between the proposed CY 2010 payment with all changes as

proposed in this rule and current CY 2009 payment. This payment amount is computed by multiplying the wage adjusted composite rate with the drug add-on for each provider times the number of dialysis treatments from the CY 2008 claims. The CY 2010 proposed payment is the composite rate for each provider (with the proposed 15.0 percent drug add-on) times dialysis treatments from CY 2008 claims. The CY 2009 current payment is the composite rate for each provider (with the current 15.2 percent drug add-on) times dialysis treatments from CY 2008 claims.

The overall impact to ESRD providers in aggregate is 0.8 percent as shown in Table 42. Most ESRD facilities will see an increase in payments as a result of the MIPPA provision. While the MIPPA provision includes a 1 percent increase to the ESRD composite rate, this 1 percent increase does not apply to the drug add-on to the composite rate. For this reason, the impact of all changes in this proposed rule is a 0.8 percent increase for all ESRD providers. Overall, payments to independent ESRD facilities will increase by 0.8 percent and payments to hospital-based ESRD facilities will increase by 1.0 percent.

TABLE 42—IMPACT OF CY 2010 CHANGES IN PAYMENTS TO HOSPITAL BASED AND INDEPENDENT ESRD FACILITIES

[Percent change in composite rate payments to ESRD facilities]

	Number of facilities	Number of dialysis treatments (in millions)	Effect of changes in wage index [1] (percent)	Effect of changes in wage index and of MIPPA provision [2] (percent)	Overall effect of wage index MIPPA & drug add-on [3] (percent)
1	2	3	4	5	6
All Providers	4,991	37.1	0.0	1.0	0.8
Independent	4,432	33.5	0.0	1.0	0.8
Hospital Based	559	3.6	0.2	1.2	1.0
By Facility Size:					
Less than 5,000 treatments	1,807	5.3	0.1	1.1	0.9
5,000 to 9,999 treatments	1,998	14.6	0.0	1.0	0.9
Greater than 9,999 treatments	1,186	17.2	−0.1	0.9	0.8
Type of Ownership:					
Profit	4,062	30.5	0.0	1.0	0.8
Nonprofit	929	6.5	0.1	1.1	0.9
By Geographic Location:					
Rural	1,093	6.0	0.2	1.2	1.0
Urban	3,898	31.0	0.0	1.0	0.8
By Region:					
New England	156	1.3	0.3	1.3	1.1
Middle Atlantic	571	4.6	−0.2	0.8	0.6
East North Central	808	5.8	−0.1	0.9	0.7
West North Central	382	2.0	0.3	1.3	1.1
South Atlantic	1,129	8.5	0.1	1.1	0.9
East South Central	388	2.8	0.2	1.2	1.0
West South Central	679	5.3	0.0	1.0	0.8
Mountain	279	1.6	0.9	1.9	1.7
Pacific	562	4.8	−0.1	0.9	0.7
Puerto Rico & Virgin Islands	37	0.4	−2.4	−1.4	−1.6

[1] This column shows the overall effect of wage index changes on ESRD providers. Composite rate payments are computed using the proposed CY 2010 wage indexes which are compared to composite rate payments using the current CY 2009 wage indexes.

[2] This column shows the effect of the changes in the Wage Indexes and the MIPPA provision which includes a 1 percent increase to the composite rate. This provision is effective January 1, 2010.

[3] This column shows the percent change between CY 2010 and CY 2009 composite rate payments to ESRD facilities. The CY 2010 payments include the CY 2010 wage adjusted composite rate, a 1 percent increase due to MIPPA effective January 1, 2010 and the drug add-on of 15.0 percent. The CY 2009 payments include the CY 2009 wage adjusted composite rate, a 1 percent increase and site neutral rates effective January 1, 2009 and the drug add-on of 15.2 percent. This column shows the effect of wage index, MIPPA, and drug add-on changes.

G. Chiropractic Demonstration—Application of Budget Neutrality

As discussed in section II.J. of this proposed rule, we are proposing to recoup the $50 million in expenditures from this demonstration over a 5-year period rather than over a 2-year period. We would recoup $10 million each year through adjustments to the PFS for all chiropractors in CYs 2010 through 2014.

To implement this required BN adjustment, we would reduce the payment amount under the PFS for the chiropractic CPT codes (that is, CPT codes 98940, 98941, and 98942) by 2 percent.

H. Comprehensive Outpatient Rehabilitation Facilities (CORF) and Rehabilitation Agency Issues

The revisions to the conditions of participation (CoP) discussed in section II.K. of this proposed rule make technical corrections and update the regulations to reflect current industry standards for respiratory therapists. The revisions to the regulations will clarify the qualifications necessary for respiratory therapists' to continue to qualify to furnish respiratory therapy services to CORF patients. These changes are similar to prior rules and will have no impact on CORFs cost.

I. Physician Self-Referral Provisions

As discussed in section II.N. of this proposed rule, we expect that our proposed clarification of the physician stand in the shoes provisions will assist designated health services entities in structuring legitimate compensation arrangements. Furthermore, like other physician self-referral policies, we anticipate that this clarification will

result in savings to the Medicare program by reducing overutilization and anti-competitive business arrangements. We cannot gauge with any certainty the extent of these savings to the program.

K. Durable Medical Equipment Related Issues

1. Damages Process

In section II.O.1. of this proposed rule, we propose to establish a one-time process that will only impact those suppliers who were awarded a contract and were potentially damaged by the termination of their supplier contracts by MIPPA. The DMEPOS Competitive Bidding Program that was implemented on July 1st, 2008, awarded contracts to 329 suppliers. The following factors may be considered by a contract supplier before deciding to submit a claim:

- The contract itself stipulated that the contract is subject to any changes to the statute or regulations that affect the Medicare program;
- The contract does not guarantee any amount of business or profits, therefore, an efficient business would not be expected to incur large expenses without any guaranteed increase in business and profits;
- The contract stipulates that CMS shall not pay for any expenses incurred by the supplier for the work performed under the contract other than for payment of Medicare claims authorized pursuant to the contract;
- Upon termination of the contracts by MIPPA, payments reverted back to the fee schedule amount, which was on average 26 percent higher than under the DMEPOS Competitive Bidding Program.
- There is a required responsibility under contract law for a company to take action to mitigate expenses to any stop work order.
- CMS listed the winning suppliers on the Medicare Web site at *http://www.Medicare.gov* in the supplier locator tool, a supplier is allowed to keep any new customers they may have obtained as a result of being listed on the supplier locator tool.

By mentioning the list above, we are not suggesting that there would not be legitimate claims for damages. However, these are factors that a supplier may consider when deciding whether to submit a claim for damages.

Based on these reasons and because there have been so few inquiries or responses to the reference in the MIPPA to damages (fewer than 7 suppliers), we believe that as few as 1 percent of the 329 winning suppliers may make a claim for damages. However, as a high estimate, we would estimate that approximately 76 percent of the suppliers (250) may submit a claim. We anticipate that it will take approximately 3 hours at $34/hour (3 × $34 = $102) for an accountant and a company official to review and gather the necessary documents to file a claim for a total of $25,500 (250 × $102). The hourly accountant rate was based on the Bureau of Labor Statistics data collected for June 2006 which was then adjusted to account for inflation. We estimate that this regulation will not have a large budgetary impact. The total cost range of $408 to $25,500 for potential claims from contract suppliers will not result in expenditures of $133 million or more annually. An analysis of the damage payments that may result would be dependent upon an evaluation of the actual claims once they are received.

2. Grandfathering Process

In section II.O.2. of this proposed rule, we are proposing to revise the definition of a *grandfathered item* to refer to all rented items within a competitively bid product category that the supplier currently rents. The proposed definition of a *grandfathered item* would avoid confusion, on the part of beneficiaries, regarding rented DME items for which a noncontract supplier is willing or not willing to be a grandfathered supplier. Under the revised definition, a noncontract supplier would have to choose to be either a grandfathered supplier for all or for none of the DME rented items within a product category that the supplier currently provides. We believe that it would be easier for beneficiaries to recognize which items a supplier is grandfathering or not grandfathering if the supplier's election concerning grandfathering was made by product category rather than making separate choices for each individual HCPCS code.

We also believe the revision of this definition would have a negligible impact on suppliers as product categories consist of related items routinely provided by suppliers. We are only requiring a supplier to provide those rented items within a product category that the supplier was currently furnishing at the start of the competitive bidding program.

While difficult to estimate, we believe that based on 2008 data, there were approximately 1,850 suppliers in the 9 CBAs, for which we will be doing the Round 1 rebid that rented competitively bid items, on average at different points in time during 2008. Therefore, we are using this number to indicate how many suppliers would be renting a DME competitively bid item at the start of the competitive bid program. We believe some suppliers may decide not to bid because of the cost of bidding and accreditation requirements while other suppliers may not qualify for a contract. Since not all suppliers will be awarded contracts and some may not choose to submit a bid, we estimate that in the worst case scenario there will be 1,450 suppliers that will not be awarded contracts, would be renting DME competitive bid items at the time the program is implemented.

Based on our experience from the competitive bidding demonstrations, of the 1,450 suppliers who are not awarded a contract, we expect 90 percent or 1,305 of these noncontract suppliers will offer to be grandfathered suppliers (0.90 × 1,450 = 1,305) and 10 percent or 145 (0.10 × 1,450 = 145) of the suppliers will choose not to grandfather. We believe most suppliers will not want to pick up their items before the end of the full rental period.

Based on 2008 data, we estimate that there will be 96,000 beneficiaries who reside in a CBA and are renting competitively bid items from suppliers at the start of the round 1 rebid. Based on the 2007 round 1 of the competitive bidding program, we estimate that there would be 74,880 (96,000 × 0.78 = 74,880) beneficiaries who would be renting items from a noncontract supplier.

Notification Requirement for Suppliers That Choose to Grandfather

a. Notification to CMS

For those suppliers that choose to grandfather (1,305), we estimate that it would take the supplier on average 2 hours to develop the 30-day notification that it is required to send to CMS. We estimate that the cost to the supplier to develop the 30-day notification to CMS would be $89.60 for skilled administrative staff (2 hours × $44.80 per hour). The $44.80 is based on 2009 data from the Bureau of Labor Statistics plus an increase for overhead of 40 percent. We estimate that the cost to the supplier to send the notification to CMS would be $5.51 for clerical staff (0.25 hour to send the notification × $22.02 per hour = $5.51). The $22.02 is based on 2009 data from the Bureau of Labor Statistics plus an increase for overhead of 40 percent. We estimate the cost of supplies necessary to send the notification would be $2.00. The total cost for sending the notification would be $7.51 which includes the cost of clerical staff ($5.51) and supplies ($2.00). The individual costs for all suppliers to notify CMS would be

$97.11 ($89.60 for development of the letter + $7.51 for preparing and sending each notification = $97.11). The overall cost for suppliers to notify CMS would be approximately $126,728.55 ($97.11 per supplier × 1,305 suppliers = $126,728.55).

b. Notification to the Beneficiary

We estimate based on 2008 data, we expect that there will be 74,880 beneficiaries who would have been renting competitive bid items from a noncontract supplier at the start of the round 1 rebid of the CBP. Of the 74,880, we believe that approximately 100 percent of these beneficiaries will accept the offer to continue to rent competitively bid items from the noncontract supplier that offers to be a grandfathered supplier. We believe that the beneficiaries will choose to continue to rent from a grandfathered supplier if given the choice because it would be more convenient, assure continuity of care, and eliminate the need to have equipment taken from their home.

Based upon the number of suppliers and beneficiaries, we estimate that there would be an average of 52 beneficiaries per supplier that was not awarded a contract (74,880 beneficiaries/1,450 suppliers = 52). Therefore, we estimate that each noncontract supplier that chooses to grandfather would send the 30-day notification on average to 52 beneficiaries.

We expect that the cost of developing the 30-day notification to a beneficiary would be equivalent to the cost of developing the 30-day notification to CMS ($89.60 per notification). We also expect the cost of sending the 30-day notification per beneficiary to be equivalent to sending the 30-day notification to CMS ($7.51 per notification). The total costs for the 30-day notification to beneficiaries for suppliers that choose the grandfathering option would be $89.60 for development of the letter, and $7.51 for preparing and sending each notification. To calculate the total cost we multiplied $7.51 × 52 beneficiaries and added the development cost for the letter of $89.60 for a total of $480.12 per supplier. The overall cost for these suppliers to provide the 30-day notification to their beneficiaries would be approximately $626,556.60 ($480.12 per supplier × 1,305 suppliers = $626,556.60).

Notification Requirement for Suppliers That Choose Not to Grandfather

a. 30-Day Notification to the Beneficiary

We expect that suppliers who choose not to grandfather will incur costs equivalent to the cost of developing and sending the 30-day notification to a beneficiary by those suppliers that choose to grandfather. The overall cost for all suppliers who choose not to grandfather to provide the 30-day notification to the beneficiary is approximately $69,617.40 ($480.12 total cost per supplier × 145 non-grandfathered suppliers = $69,617.40). The estimate of 145 suppliers not choosing to be grandfathered suppliers represents 10 percent of the total number of noncontract suppliers.

While the cost for the 30-day notification to beneficiaries will be exactly the same for all suppliers, those who choose not to become a grandfathered supplier will also incur the cost of the 10-day and 2-day notification.

b. 10-Day and 2-Day Notification

For the 10-day notification to a beneficiary, we estimate the supplier would make at least 1 phone call that would take an average of 15 minutes to discuss that the beneficiary must switch to a contract supplier, the schedule for picking up the current equipment by the noncontract supplier, and the delivery of new equipment by the contract supplier. For the 2-day notification to the beneficiary, we estimate that the supplier would make at least 1 phone call that would take an average of 15 minutes to ensure that all of the arrangements are finalized and to answer any last minute questions. We anticipate that clerical staff would perform both of these tasks.

The estimated cost of the 10-day notification totals $5.51 (.25 of an hour × $22.02 per hour for clerical staff based on the 2009 Bureau of Labor Statistics including overhead = $5.51). The estimated cost of the 2-day notification totals $5.51 (.25 of an hour × $22.02 per hour for clerical staff based on the 2009 Bureau of Labor Statistics including overhead = $5.51). Therefore, the 10-day and 2-day notifications for each supplier would cost approximately $11.02. The total cost for each supplier would be approximately $573.04 ($11.02 × 52 beneficiaries = $573.04). The overall impact for all suppliers to make the 10-day and 2-day notifications would be approximately $83,090.80 (145 suppliers × $573.04 per supplier = $83,090.80).

We anticipate that this proposed process will not place a greater burden on the overall small supplier community. This process is only going to affect those small suppliers that were renting items when the competitive bidding program begins and who did not win a contract. The burden on these suppliers would generally be less because small suppliers will have fewer beneficiaries to furnish notifications to.

As an alternative, we considered relying on suppliers to develop their own schedule for informing beneficiaries regarding grandfathering. This alternative would have left the beneficiaries vulnerable to having equipment removed from the home before new equipment was delivered. The process proposed in this regulation ensures the beneficiaries can make an informed decision about the transition policy that works best for them. The alternative we selected ensures the beneficiaries will have continued access to medically necessary items and be properly informed about the steps they must take so that their services will not be interrupted.

U. Alternatives Considered

This proposed rule contains a range of policies, including some provisions related to specific MIPPA provisions. The preceding preamble provides descriptions of the statutory provisions that are addressed, identifies those policies when discretion has been exercised, responds to comments on our proposals, presents rationale for our decisions and, where relevant, alternatives that were considered.

V. Impact on Beneficiaries

There are a number of changes in this proposed rule that would have an effect on beneficiaries. In general, we believe these changes, including the refinements of the PQRI with its focus on measuring, submitting, and analyzing quality data, the coding provisions related to the IPPE and consultation services, the changes with respect to telehealth services, the kidney disease patient education, pulmonary rehabilitation and intensive cardiac rehabilitation proposals will have a positive impact and improve the quality and value of care provided to Medicare beneficiaries. Additionally, the proposed grandfathering process for DME suppliers will help ensure that beneficiaries are contacted and informed about this process and the choices they have concerning whether or not to use a grandfathered supplier. Moreover, the notice will help to ensure that beneficiaries do not have necessary DME equipment taken from them unexpectedly by a noncontact supplier.

As explained in more detail subsequently in this section, the regulatory provisions may affect beneficiary liability in some cases. Most changes aggregate in beneficiary liability due to a particular provision would be a function of the coinsurance (20 percent if applicable for the particular

provision after the beneficiary has met the deductible). Beneficiary liability would also be impacted by the effect of the aggregate cost (savings) of the provision on the standard calculation of the Medicare Part B premium rate (generally 25 percent of the provision's cost or savings). In 2010, total cost sharing (coinsurance and deductible) per Part B enrollee associated with PFS services is estimated to be $399. In addition, the portion of the 2010 standard monthly Part B premium attributable to PFS services is estimated to be $25.00.

To illustrate this point, as shown in Table 39, the 2009 national payment amount in the nonfacility setting for CPT code 99203 (Office/outpatient visit, new), is $91.97 which means that in 2009 a beneficiary is responsible for 20 percent of this amount, or $18.39. Based on this rule, the 2010 national payment amount in the nonfacility setting for CPT code 99203, as shown in Table 39, is $81.00 which means that, in 2010, the beneficiary coinsurance for this service would be $16.20.

Policies discussed in this rule, such as the coding changes with respect to the RVUs for IPPE and the changes to consultation services, would similarly impact beneficiaries' coinsurance.

W. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in Table 43, we have prepared an accounting statement showing the classification of the expenditures associated with this proposed rule. This estimate includes the incurred benefit impact associated with the estimated CY 2010 PFS update based on the 2009 Trustees Report baseline, as well as certain MIPPA provisions. All estimated impacts are classified as transfers.

TABLE 43—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES CY 2010

Category	Transfers
Annualized Monetized Transfers	Estimated decrease in expenditures (from CY 2009 to CY 2010) of $13.3 Billion.
From Whom To Whom?	Federal Government to physicians, other practitioners and providers and suppliers who receive payment under Medicare.
Annualized Monetized Transfers	Estimated increase in expenditures of $110 Million for MIPPA Provisions (sections 102 and 152(b)).
From Whom To Whom?	Federal Government to providers.

In accordance with the provisions of Executive Order 12866, this proposed rule was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 411

Kidney diseases, Medicare, Physician Referral, Reporting and record keeping requirements.

42 CFR Part 414

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping.

42 CFR Part 415

Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 485

Grant programs—health, Health facilities, Medicaid, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services would amend 42 CFR chapter IV as set forth below:

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

1. The authority citation for part 410 continues to read:

Authority: Secs. 1102, 1834, 1871, and 1893 of the Social Security Act (42 U.S.C. 1302, 1395m, 1395hh, and 1395ddd).

Subpart B—Medical and Other Health Services

2. Section 410.30 is amended by revising paragraph (b) to read as follows:

§ 410.30 Prescription drugs used in immunosuppressive therapy.

* * * * *

(b) *Eligibility.* For drugs furnished on or after December 21, 2000, coverage is available only for prescription drugs used in immunosuppressive therapy, furnished to an individual who received an organ or tissue transplant for which Medicare payment is made, provided the individual is eligible to receive Medicare Part B benefits.

* * * * *

3. Section 410.47 is added to read as follows:

§ 410.47 Pulmonary rehabilitation program: Conditions for coverage.

(a) *Definitions.*

Individualized treatment plan means a written plan established, reviewed, and signed by a physician every 30 days, that describes all of the following:

(i) The individual's diagnosis.

(ii) The type, amount, frequency, and duration of the items and services under the plan.

(iii) The goals set for the individual under the plan.

Outcomes assessment means a written evaluation of the patient's progress as it relates to the individual's rehabilitation which includes the following:

(i) Beginning and end evaluations, based on patient-centered outcomes, which are conducted by the physician at the start and end of the program.

(ii) Objective clinical measures of effectiveness of the PR program for the individual patient, including exercise performance and self-reported measures of shortness of breath and behavior.

Physician means a doctor of medicine or osteopathy as defined in section 1861(r)(1) of the Act.

Physician-prescribed exercise means physical activity, including aerobic exercise, prescribed and supervised by a physician that improves or maintains an individual's pulmonary functional level.

Psychosocial assessment means a written evaluation of an individual's mental and emotional functioning as it relates to the individual's rehabilitation or respiratory condition.

Pulmonary rehabilitation means a physician-supervised program for COPD and certain other chronic respiratory diseases designed to optimize physical and social performance and autonomy.

(b) *Beneficiaries who may be covered.* (1) Medicare covers pulmonary rehabilitation for beneficiaries with moderate to severe COPD (defined as

GOLD classification II and III), when referred by the physician treating the chronic respiratory disease.

(2) Additional medical indications for coverage for pulmonary rehabilitation program services may be established through a national coverage determination (NCD).

(c) *Components.* Pulmonary rehabilitation includes all of the following components:

(1) *Physician-prescribed exercise.* This physical activity includes techniques such as exercise conditioning, breathing retraining, step and strengthening exercises. Some aerobic exercise must be included in each pulmonary rehabilitation session.

(2) *Education or training.* (i) Education or training closely and clearly related to the individual's care and treatment which is tailored to the individual's needs.

(ii) Education includes information on respiratory problem management and, if appropriate, brief smoking cessation counseling.

(iii) Any education or training prescribed must assist in achievement of individual goals towards independence in activities of daily living, adaptation to limitations and improved quality of life.

(3) *Psychosocial assessment.* The psychosocial assessment must meet the criteria as defined in paragraph (a) of this section and includes:

(i) An assessment of those aspects of an individual's family and home situation that affects the individual's rehabilitation treatment.

(ii) A psychosocial evaluation of the individual's response to and rate of progress under the treatment plan.

(4) *Outcomes assessment.* The outcomes assessment must meet the criteria as defined in paragraph (a) of this section.

(5) *Individualized treatment plan.* The individualized treatment plan must be established, reviewed, and signed by a physician every 30 days.

(d) *Settings.* (1) Medicare Part B pays for a pulmonary rehabilitation in the following settings:

(i) Physician's offices.

(ii) Hospital outpatient settings.

(2) All settings must have the following available for immediate use and accessible at all times:

(i) The necessary cardio-pulmonary, emergency, diagnostic, and therapeutic life-saving equipment accepted by the medical community as medically necessary (for example, oxygen, cardiopulmonary resuscitation equipment, and defibrillator) to treat chronic respiratory disease.

(ii) A physician must be immediately available and accessible for medical consultations and emergencies at all times when services are being provided under the program. This provision is satisfied if the physician meets the requirements for direct supervision for physician office services at § 410.26(b)(5) of this subpart as described in § 410.26(a)(2) of this subpart (defined through cross references to § 410.32(b)(3)(ii) of this subpart); and for hospital outpatient services at § 410.27(f) of this subpart.

(e) *Physician standards.* Medicare Part B pays for pulmonary rehabilitation services provided by a physician only if the physician meets all of the following requirements:

(1) Has expertise in the management of individuals with respiratory pathophysiology.

(2) Is licensed to practice in the State in which the pulmonary rehabilitation program is offered.

(3) Is responsible and accountable for the pulmonary rehabilitation program.

(4) Is involved substantially in consultation with staff in directing the progress of the individual in the program.

(f) *Limitations on coverage: Sessions.* Medicare Part B pays for services provided in connection with a pulmonary rehabilitation exercise program for up to 36 sessions, no more than one session per day.

(g) *Effective date.* Coverage for pulmonary rehabilitation program services is effective January 1, 2010.

4. Section 410.48 is added to read as follows:

§ 410.48 Kidney disease education services.

(a) *Definitions.*

Kidney disease patient education services means face-to-face educational services provided to patients with Stage IV chronic kidney disease.

Physician means a physician as defined in section 1861(r)(1) of the Act.

Qualified person means either of the following healthcare entities that meets the qualifications and requirements specified in this section to provide kidney disease patient education services—

(i) One of the following healthcare professionals who furnishes services for which payment may be made under the physician fee schedule:

(A) Physician (as defined in section 1861(r)(1) of the Act).

(B) Physician assistant (as defined in section 1861(aa)(5) of the Act and § 410.74 of this subpart).

(C) Nurse practitioner (as defined in section 1861(aa)(5) of the Act and § 410.75 of this subpart).

(D) Clinical nurse specialist (as defined in section 1861(aa)(5) of the Act and § 410.76 of this subpart),

(ii)(A) Hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or hospice that is located in a rural area as defined in § 412.64(b)(ii)(C); or

(B) A hospital or critical access hospital that is treated as being rural under § 412.103 of this chapter.

Renal dialysis facility means a unit which is approved to furnish dialysis service(s) directly to end-stage renal disease (ESRD) patients, as defined in § 405.2102 of this chapter.

Stage IV chronic kidney disease means kidney damage with a severe decrease in glomerular filtration rate (GFR) quantitatively defined by a GFR value of 15–29 ml/min/1.73m^2, using the Modification of Diet in Renal Disease (MDRD) Study formula.

(b) *Covered beneficiaries.* Medicare Part B covers outpatient kidney disease patient education services if the beneficiary meets all of the conditions and requirements of this subpart, including all of the following:

(1) Is diagnosed with Stage IV chronic kidney disease.

(2) Obtains a referral from the physician (as defined in section 1861(r)(1) of the Act) managing the beneficiary's kidney condition.

(c) *Qualified person.* (1) Medicare Part B covers outpatient kidney disease patient education services provided by a qualified person as defined in paragraph (a) of this section and must be able to properly receive Medicare payment under part 424 of this chapter.

(2) A qualified person does not include either of the following:

(i) A hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency or hospice if kidney disease patient education services are provided outside of a rural area as defined in § 412.64(b)(ii)(C) of this chapter unless the services are furnished in a hospital or critical access hospital that is treated as being in a rural area under § 412.103 of this chapter.

(ii) A renal dialysis facility, as defined in § 405.2102 of this chapter.

(d) *Standards for content of kidney disease patient education services.* The content of the kidney disease patient education services includes the following:

(1) The management of comorbidities including for the purpose of delaying the need for dialysis which includes, but not limited to, the following topics:

(i) Prevention and treatment of cardiovascular disease.

(ii) Prevention and treatment of diabetes.

(iii) Hypertension management.

(iv) Anemia management.

(v) Bone disease and disorders of calcium and phosphorus metabolism management.

(vi) Symptomatic neuropathy management.

(vii) Impairments in functioning and well-being.

(2) The prevention of uremic complications which includes, but not limited to, the following topics:

(i) Information on how the kidneys work and what happens when the kidneys fail.

(ii) Understanding if remaining kidney function can be protected, preventing disease progression, and realistic chances of survival.

(iii) Diet and fluid restrictions.

(iv) Medication review, including how each medication works, possible side effects and minimization of side effects, the importance of compliance, and informed decision-making if the patient decides not to take a specific drug.

(3) Therapeutic options, treatment modalities and settings, including a discussion of the advantages and disadvantages of each treatment option and how the treatments replace the kidney:

(i) Hemodialysis, both at home and in-facility.

(ii) Peritoneal dialysis (PD), including intermittent PD, continuous ambulatory PD, and continuous cycling PD, both at home and in-facility.

(iii) All vascular access options.

(iv) Transplantation.

(4) Opportunities for beneficiaries to actively participate in the choice of therapy and be tailored to meet the needs of the individual beneficiary involved which includes, but not limited to, the following topics:

(i) Physical symptoms.

(ii) Impact on family and social life.

(iii) Exercise.

(iv) The right to refuse treatment.

(v) Impact on work and finances.

(vi) The meaning of test results.

(vii) Psychological impact.

(5) Qualified persons must develop outcomes assessments designed to measure beneficiary knowledge about chronic kidney disease and its treatment.

(i) The outcomes assessments serve to assess program effectiveness of preparing the beneficiary to make informed decisions about their healthcare options related to chronic kidney disease.

(ii) The outcomes assessments serve to assess the program's effectiveness in meeting the communication needs of underserved populations, including persons with disabilities, persons with limited English proficiency, and persons with health literacy needs.

(iii) The assessment must be administered to the beneficiary during a kidney disease education session.

(iv) The outcomes assessments must be made available to CMS upon request.

(e) *Limitations for coverage of kidney disease education services.* (1) Medicare Part B makes payment for up to 6 sessions of kidney disease patient education services.

(2) A session is 60 minutes long and may be provided individually or in group settings of 2 to 20 individuals who need not all be Medicare beneficiaries.

(f) *Effective date.* Medicare Part B covers kidney disease patient education services for dates of service on or after January 1, 2010.

5. Section 410.49 is added to read as follows:

§ 410.49 Cardiac rehabilitation program and intensive cardiac rehabilitation program: Conditions of coverage.

(a) *Definitions.*

Cardiac rehabilitation (CR) means a physician-supervised program that furnishes physician prescribed exercise, cardiac risk factor modification, psychosocial assessment, and outcomes assessment.

Individualized treatment plan means a written plan tailored to each individual patient that includes all of the following:

(i) A description of the individual's diagnosis.

(ii) The type, amount, frequency, and duration of the items and services furnished under the plan.

(iii) The goals set for the individual under the plan.

Intensive cardiac rehabilitation (ICR) means a physician-supervised program that furnishes cardiac rehabilitation and has shown, in peer-reviewed published research that it improves patients' cardiovascular disease through specific outcome measurements described in paragraph (c) of this section.

Physician means a doctor of medicine or osteopathy as defined in section 1861(r)(1) of the Act.

Outcomes assessment means an evaluation of progress as it relates to the individual's rehabilitation which includes all of the following:

(i) Minimally, assessments from the commencement and conclusion of cardiac rehabilitation and intensive cardiac rehabilitation, based on patient-centered outcomes which must be measured by the physician immediately at the beginning of the program and at the end of the program.

(ii) Objective clinical measures of exercise performance and self-reported measures of exertion and behavior.

Physician-prescribed exercise means aerobic exercise combined with other types of exercise (that is, strengthening, stretching) as determined to be appropriate for individual patients by a physician.

Psychosocial assessment means an evaluation of an individual's mental and emotional functioning as it relates to the individual's rehabilitation which includes an assessment of those aspects of an individual's family and home situation that affects the individual's rehabilitation treatment, and psychosocial evaluation of the individual's response to and rate of progress under the treatment plan.

(b) *General rule.* (1) *Covered beneficiary rehabilitation services.* Medicare part B covers cardiac rehabilitation and intensive cardiac rehabilitation programs, as defined in this section, for beneficiaries who have experienced one or more of the following:

(i) An acute myocardial infarction within the preceding 12 months.

(ii) A coronary artery bypass surgery.

(iii) Current stable angina pectoris.

(iv) Heart valve repair or replacement.

(v) Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting.

(vi) A heart or heart-lung transplant.

(vii) For cardiac rehabilitation only, other conditions as specified through a national coverage determination.

(2) *Components of a cardiac rehabilitation program.* Cardiac rehabilitation programs must include all of the following:

(i) Physician-prescribed exercise each day cardiac rehabilitation items and services are furnished.

(ii) Cardiac risk factor modification, including education, counseling, and behavioral intervention, tailored to the patients' individual needs.

(iii) Psychosocial assessment.

(iv) Outcomes assessment.

(v) An individualized treatment plan detailing how components are utilized for each patient.

(3) *Settings.* (i) Medicare Part B pays for cardiac rehabilitation and intensive cardiac rehabilitation in one of the following settings:

(A) A physician's office.

(B) A hospital outpatient setting.

(ii) All settings must have a physician, as defined in this section, immediately available and accessible for medical

consultations and emergencies at all times when items and services are being furnished under the program. This provision is satisfied if the physician meets the requirements for direct supervision for physician office services at § 410.26(b)(5) of this subpart as described in § 410.26(a)(2) of this subpart (defined through cross references to § 410.32(b)(3)(ii) of this subpart); and for hospital outpatient services at § 410.27 of this subpart.

(c) *Standards for an intensive cardiac rehabilitation program.* (1) To be designated an intensive cardiac rehabilitation program, a program in an approved setting must apply for designation. To be designated as an intensive cardiac rehabilitation program, the program must demonstrate through peer-reviewed, published research that it accomplishes one or more of the following for its patients:

(i) Positively affected the progression of coronary heart disease.

(ii) Reduces the need for coronary bypass surgery.

(iii) Reduces the need for percutaneous coronary interventions.

(iv) A statistically significant reduction in 5 or more of the following measures for patients from their levels before cardiac rehabilitation services to after cardiac rehabilitation services:

(A) Low density lipoprotein.

(B) Triglycerides.

(C) Body mass index.

(D) Systolic blood pressure.

(E) Diastolic blood pressure.

(F) The need for cholesterol, blood pressure, and diabetes medications.

(2) A list of designated intensive cardiac rehabilitation programs will be posted to the CMS Web site and listed in the **Federal Register**.

(3) To ensure that intensive cardiac rehabilitation programs maintain the designated quality of rehabilitation, sites must demonstrate that patients enrolled continue to achieve beneficial outcomes by submitting outcomes data annually from the date of approval as an intensive cardiac rehabilitation site.

(i) Sites will be notified of continued compliance via a re-evaluation date posted to the CMS Web site.

(ii) Sites that are no longer designated as approved intensive cardiac rehabilitation programs, due to poor outcomes data resulting in noncompliance, will be notified in writing and removed from the CMS Web site.

(d) *Standards for physicians responsible for cardiac rehabilitation programs.* A physician who serves as the program Medical Director responsible for general or intensive cardiac rehabilitation programs, and who, in consultation with staff, is involved in directing the progress of individuals in the program must possess all of the following:

(1) Expertise in the management of individuals with cardiac pathophysiology.

(2) Be licensed to practice medicine in the State in which the cardiac rehabilitation program is offered.

(e) *Standards for supervising-physicians.* Physicians acting as the supervising-physician must possess all of the following:

(1) Expertise in the management of individuals with cardiac pathophysiology.

(2) Be licensed to practice medicine in the State in which the cardiac rehabilitation program is offered.

(f) *Limitations for coverage of cardiac rehabilitation programs.* (1) *General cardiac rehabilitation.* The number of general cardiac rehabilitation program sessions are limited to a minimum of 2 1-hour sessions per week and a maximum of 2 1-hour sessions per day for up to 36 sessions over up to 18 weeks. Medicare contractors have discretion to expand these limitations to not exceed 72 sessions for 36 weeks.

(2) *Intensive cardiac rehabilitation:* Intensive cardiac rehabilitation program sessions are limited to 72 1-hour sessions (as defined in section 1848(b)(5) of the Act), up to 6 sessions per day, over a period of up to 18 weeks.

6. Section 410.78 is amended by—

A. Revising the introductory text of paragraph (b).

B. Revising paragraph (e).

The revisions read as follows:

§ 410.78 Telehealth services.

* * * * *

(b) *General rule.* Medicare Part B pays for office and other outpatient visits, professional consultation, psychiatric diagnostic interview examination, individual psychotherapy, pharmacologic management, end-stage renal disease-related services included in the monthly capitation payment (except for one visit per month to examine the access site), individual medical nutrition therapy, the neurobehavioral status exam, follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals and SNFs, and individual health and behavior assessment and intervention services furnished by an interactive telecommunications system if the following conditions are met:

* * * * *

(e) *Limitations.* (1) A clinical psychologist and a clinical social worker may bill and receive payment for individual psychotherapy via a telecommunications system, but may not seek payment for medical evaluation and management services.

(2) The physician visits required under § 483.40(c) of this title may not be furnished as telehealth services.

* * * * *

Subpart I—Payment of SMI Benefits

7. Section 410.155 is amended by—

A. Revising paragraphs (a), (b)(2)(i), (b)(2)(ii), (b)(2)(iv), (b)(2)(v), and (c).

B. Adding paragraph (b)(3).

The revisions and addition read as follows:

§ 410.155 Outpatient mental health treatment limitation.

(a) *Limitation.* For services subject to the limitation as specified in paragraph (b) of this section, the percentage of the expenses incurred for such services during a calendar year that is considered incurred expenses under Medicare Part B when determining the amount of payment and deductible under § 410.152 and § 410.160, respectively, is as follows:

(1) For expenses incurred in years before 2010, 62½ percent.

(2) For expenses incurred in 2010 and 2011, 68¾ percent.

(3) For expenses incurred in 2012, 75 percent.

(4) For expenses incurred in 2013, 81¼ percent.

(5) For expenses incurred in CY 2014 and subsequent years, 100 percent.

(b) * * *

(2) *Services not subject to the limitation.* Services not subject to the limitation include the following:

(i) Services furnished to a hospital inpatient.

(ii) Brief office visits for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental, psychoneurotic, or personality disorders *billed under HCPCS code M0064 (or its successor).*

(iii) * * *

(iv) Diagnostic services, such as diagnostic psychological *and neuropsychological* testing, that are performed to establish a diagnosis.

(v) Medical management *services billed under CPT code 90862 (or its successor),* as opposed to psychotherapy, when furnished to a patient diagnosed with Alzheimer's disease or a related disorder.

(3) *Payment amounts.* The Medicare payment amount and the patient liability amounts for outpatient mental health services subject to the limitation for each year during which the limitation is phased out are as follows:

Calendar year	Recognized incurred expenses (%)	Patient pays (%)	Medicare pays (%)
CY 2009 and prior calendar years	62.50	50	50
CYs 2010 and 2011	68.75	45	55
CY 2012	75.00	40	60
CY 2013	81.25	35	65
CY 2014	100.00	20	80

(c) *General formula.* A general formula for calculating the amount of Medicare payment and the patient liability for outpatient mental health services subject to the limitation is as follows:

(1) Multiply the Medicare approved amount by the percentage of incurred expenses that is recognized as incurred expenses for Medicare payment purposes for the year involved;

(2) Subtract from this amount the amount of any remaining Part B deductible for the patient and year involved; and,

(3) Multiply this amount by 0.80 (80 percent) to obtain the Medicare payment amount.

(4) Subtract the Medicare payment amount from the Medicare-approved amount to obtain the patient liability amount.

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

8. The authority citation for Part 411 continues to read as follows:

Authority: Secs. 1102, 1860D–1 through 1860D–42, 1871, and 1877 of the Social Security Act (42 U.S.C. 1302, 1395w–101 through 1395w–152, 1395hh, and 1395nn).

Subpart J—Financial Relationships Between Physicians and Entities Furnishing Designated Health Services

9. Section 411.354 is amended by revising paragraph (c)(3)(i) to read as follows:

§ 411.354 Financial relationship, compensation, and ownership or investment interest.

* * * * *

(c) * * *

(3)(i) For purposes of paragraphs (c)(1)(ii) and (c)(2)(iv), a physician who ''stands in the shoes'' of his or her physician organization is deemed to have the same compensation arrangements (with the same parties and on the same terms) as the physician organization. When applying the exceptions in § 411.355 and § 411.357 of this part to arrangements in which a physician stands in the shoes of his or her physician organization, the relevant referrals and other business generated ''between the parties'' are referrals and other business generated between the entity furnishing DHS and the physician organization (including all members, employees, and independent contractor physicians).

* * * * *

PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES

10. The authority citation for part 414 continues to read as follows:

Authority: Secs. 1102, 1871, and 1881(b)(l) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395rr(b)(l)).

Subpart A—General Provisions

§ 414.1 [Amended]

11. Amend § 414.1 by adding ''1834(e)—Implementation of accreditation standards for suppliers furnishing the technical component of advanced imaging services'' in numerical order.

Subpart B—Physicians and Other Practitioners

12. Section 414.46 is amended by revising paragraphs (d)(2) and (e) to read as follows:

§ 414.46 Additional rules for payment of anesthesia services.

* * * * *

(d) * * *

(2) The rules for medical direction differ for certain time periods depending on the nature of the qualified individual who is directed by the physician. If more than two procedures are directed on or after January 1, 1994, the qualified individuals could be AAs, CRNAs, interns, or residents. The medical direction rules apply to student nurse anesthetists only if the physician directs two concurrent cases, each of which involves a student nurse anesthetist or the physician directs one case involving a student nurse anesthetist and the other involving a CRNA, AA, intern, or resident. For services furnished on or after January 1, 2010, the medical direction rules do not apply to a single anesthesia resident case that is concurrent to another case which is paid under the medical direction payment rules as specified in paragraph (e) of this section.

* * * * *

(e) *Special payment rule for teaching anesthesiologist involved in a single resident case or two concurrent cases.* For physicians' services furnished on or after January 1, 2010, if the teaching anesthesiologist is involved in the training of physician residents in a single anesthesia case or two concurrent anesthesia cases, the fee schedule amount must be 100 percent of the fee schedule amount otherwise applicable if the anesthesia services were personally performed by the teaching anesthesiologist and the teaching anesthesiologist fulfilled the criteria in § 415.178 of this chapter. The single anesthesia resident case is the only case or concurrent to one other anesthesia case that is being medically directed by the physician.

* * * * *

13. Section 414.61 is added to read as follows:

§ 414.61 Payment for anesthesia services furnished by a teaching CRNA.

(a) *Basis for payment.* Beginning January 1, 2010, anesthesia services furnished by a teaching CRNA may be paid under one of the following conditions:

(1) The teaching CRNA, who is not under medical direction of a physician, is present with the student nurse anesthetist for the pre and post anesthesia services included in the anesthesia base units payment and is continuously present during anesthesia time in a single case with a student nurse anesthetist.

(2) The teaching CRNA, who is not under the medical direction of a physician, is involved with two concurrent anesthesia cases with student nurse anesthetists. The teaching CRNA must be present with the student nurse anesthetist for the pre and post anesthesia services included in the anesthesia base unit. For the anesthesia time of the two concurrent cases, the teaching CRNA can only be involved with those two concurrent cases and may not perform services for other patients.

(b) *Level of payment.* The allowance for the service of the teaching CRNA, furnished under paragraph (a) of this section, is determined in the same way as for a physician who personally performs the anesthesia service alone as specified in 414.46(c) of this subpart.

14. Section 414.65 is amended by revising paragraph (a)(1) to read as follows:

§ 414.65 Payment for telehealth services.

(a) * * *

(1) The Medicare payment amount for office or other outpatient visits, consultation, individual psychotherapy, psychiatric diagnostic interview examination, pharmacologic management, end-stage renal disease related services included in the monthly capitation payment (except for one visit per month to examine the access site), individual medical nutrition therapy, and individual health and behavior assessment and intervention services furnished via an interactive telecommunications system is equal to the current fee schedule amount applicable for the service of the physician or practitioner. The Medicare payment amount for follow-up inpatient telehealth consultations furnished via an interactive telecommunications system is equal to the current fee schedule amount applicable to subsequent hospital care provided by a physician or practitioner.

* * * * *

15. Section 414.68 is added to read as follows:

§ 414.68 Imaging accreditation.

(a) *Scope and purpose.* Section 1834(e) of the Act, requires the Secretary to designate and approve independent accreditation organizations for purposes of accrediting suppliers furnishing the technical component (TC) of advanced diagnostic imaging services and establish procedures to ensure that the criteria used by an accreditation organization is specific to each imaging modality. Suppliers of the TC of advanced diagnostic imaging services for which payment is made under the fee schedule established in section 1848(b) of the Act must become accredited by an accreditation organization designated by the Secretary beginning January 1, 2012.

(b) *Definitions.* As used in this section, the following definitions are applicable:

Accredited supplier means a supplier that has been accredited by a CMS-designated accreditation organization as specified in this part.

Advanced diagnostic imaging service means any of the following diagnostic services:

(i) Magnetic resonance imaging.

(ii) Computed tomography.

(iii) Nuclear medicine.

(iv) Positron emission tomography.

CMS-approved accreditation organization means an accreditation organization designated by CMS to perform the accreditation functions specified in section 1834(e) of the Act

(c) *Application and reapplication procedures for accreditation organizations.* An independent accreditation organization applying for approval or reapproval of authority to survey suppliers for purposes of accrediting suppliers furnishing the TC of advanced diagnostic imaging services is required to furnish CMS with all of the following:

(1) A detailed description of how the organization's accreditation criteria satisfy the statutory standards at section 1834(e)(3) of the Act, specifically—

(i) Qualifications of medical personnel who are not physicians and who furnish the TC of advanced diagnostic imaging services;

(ii) Qualifications and responsibilities of medical directors and supervising physicians, such as their training in advanced diagnostic imaging services in a residency program, expertise obtained through experience, or continuing medical education courses;

(iii) Procedures to ensure the reliability, clarity, and accuracy of the technical quality of diagnostic images produced by the supplier; and

(iv) Procedures to ensure the safety of persons who furnish the TC of advanced diagnostic imaging services and individuals to whom such services are furnished.

(2) An agreement to conform accreditation requirements to any changes in Medicare statutory requirements in section 1834(e) of the Act.

(3) Information that demonstrates the accreditation organization's knowledge and experience in the advanced diagnostic imaging arena.

(4) The organization's proposed fees for accreditation for each modality in which the organization intends to offer accreditation, including any plans for reducing the burden and cost of accreditation to small and rural suppliers.

(5) Any specific documentation requirements and attestations requested by CMS as a condition of designation under this part.

(6) A detailed description of the organization's survey process, including the following:

(i) Type and frequency of the surveys performed.

(ii) The ability of the organization to conduct timely reviews of accreditation applications, to include the organizations national capacity.

(iii) Description of the organizations audit procedures including random site visits, site audits, or other strategies for ensuring suppliers maintain compliance during the duration of accreditation.

(iv) Procedures for performing unannounced site surveys.

(v) Copies of the organization's survey forms.

(vi) A description of the accreditation survey review process and the accreditation status decision-making process, including the process for addressing deficiencies identified with the accreditation requirements, and the procedures used to monitor the correction of deficiencies found during an accreditation survey.

(vii) Procedures for coordinating surveys with another accrediting organization if the organization does not accredit all products the supplier provides.

(viii) Detailed information about the individuals who perform evaluations for the accreditation organization, including all of the following information:

(A) The number of professional and technical staff that are available for survey.

(B) The education, current employment and experience requirements surveyors must meet.

(C) The content and length of the orientation program.

(ix) The frequency and types of in-service training provided to survey personnel.

(x) The evaluation systems used to monitor the performance of individual surveyors and survey teams.

(xi) The policies and procedures regarding an individual's participation in the survey or accreditation decision process of any organization with which the individual is professionally or financially affiliated.

(xii) The policies and procedures used when an organization has a dispute regarding survey findings or an adverse decision.

(7) Detailed information about the size and composition of survey teams for each category of advanced medical imaging service supplier accredited.

(8) A description of the organization's data management and analysis system for its surveys and accreditation decisions, including the kinds of reports, tables, and other displays generated by that system.

(9) The organization's procedures for responding to and for the investigation

of complaints against accredited facilities, including policies and procedures regarding coordination of these activities with appropriate licensing bodies and CMS.

(10) The organization's policies and procedures for the withholding or removal of accreditation status for facilities that fail to meet the accreditation organization's standards or requirements, and other actions taken by the organization in response to noncompliance with its standards and requirements. These policies and procedures must include notifying CMS of facilities that fail to meet the requirements of the accrediting organization.

(11) A list of all currently accredited suppliers, the type and category of accreditation currently held by each supplier, and the expiration date of each supplier's current accreditation.

(12) The accreditation organization must also submit the following supporting documentation:

(i) A written presentation that demonstrates the organization's ability to furnish CMS with electronic data in ASCII comparable code.

(ii) A resource analysis that demonstrates that the organization's staffing, funding, and other resources are adequate to perform the required surveys and related activities.

(iii) A statement acknowledging that, as a condition for approval of designation, the organization agrees to the following activities:

(A) Prioritize surveys for those suppliers needing to be accredited by January 1, 2012.

(B) In the case of a supplier that is accredited before January 1, 2010, the supplier must be considered accredited as of January 1, 2012.

(C) Notify CMS, in writing, of any supplier that had its accreditation revoked, withdrawn, revised, or any other remedial or adverse action taken against it by the accreditation organization within 30 calendar days of any such action taken.

(D) Notify all accredited suppliers within 10 calendar days of the organization's removal from the list of designated accreditation organizations.

(E) Notify CMS, in writing, at least 30 calendar days in advance of the effective date of any proposed changes in accreditation requirements.

(F) Permit its surveyors to serve as witnesses if CMS takes an adverse action based on accreditation findings.

(G) Notify CMS, in writing, (electronically or hard copy) within 2 calendar days of a deficiency identified in any accreditation supplier where the deficiency poses an immediate jeopardy to the supplier's beneficiaries or a hazard to the general public.

(H) Provide, on an annual basis, summary data specified by CMS that relates to the past years' accreditations and trends.

(I) Attest that the organization will not perform any accreditation surveys of Medicare participating suppliers with which it has a financial relationship with or interest in.

(J) Conform accreditation requirements to changes in Medicare requirements.

(iv) If CMS determines that additional information is necessary to make a determination for approval or denial of the accreditation organization's application for designation, the organization is notified and afforded an opportunity to provide the additional information.

(v) CMS may visit the organization's offices to verify representations made by the organization in its application, including, but not limited to, review of documents and interviews with the organization's staff.

(vi) The accreditation organization will receive a formal notice from CMS stating whether the request for designation has been approved or denied. If approval was denied the notice includes the basis for denial and reconsideration and reapplication procedures.

(d) *Ongoing responsibilities of a CMS-approved accreditation organization.* An accreditation organization approved by CMS must undertake the following activities on an ongoing basis:

(1) Provide to CMS all of the following in written format (either electronic or hard copy):

(i) Copies of all accreditation surveys, together with any survey-related information that CMS may require (including corrective action plans and summaries of findings with respect to unmet CMS requirements).

(ii) Notice of all accreditation decisions.

(iii) Notice of all complaints related to suppliers.

(iv) Information about any supplier furnishing the TC of advanced diagnostic imaging service against which the CMS approved accreditation organization has taken remedial or adverse action, including revocation, withdrawal, or revision of the supplier's accreditation.

(v) Notice of any proposed changes in its accreditation standards or requirements or survey process. If the organization implements the changes before or without CMS' approval, CMS may withdraw its approval of the accreditation organization.

(2) Within 30 calendar days of a change in CMS requirements, an acknowledgment of CMS' notification of the change must be submitted to CMS.

(3) Permit its surveyors to serve as witnesses if CMS takes an adverse action based on accreditation findings.

(4) Within 2 calendar days of identifying a deficiency of an accredited supplier that poses immediate jeopardy to a beneficiary or to the general public, provide CMS with written notice of the deficiency and any adverse action implemented by the accreditation organization.

(5) Within 10 calendar days after CMS' notice to a CMS approved accreditation organization that CMS intends to withdraw approval of the accreditation organization, provide written notice of the withdrawal to all the CMS approved accreditation organization's accredited suppliers.

(6) Provide, on an annual basis, summary data specified by CMS that relate to the past year's accreditation activities and trends.

(d) *Continuing Federal oversight of approved accreditation organizations.* This paragraph establishes specific criteria and procedures for continuing oversight and for withdrawing approval of a CMS approved accreditation organization.

(1) *Validation audits.* CMS or its contractor may conduct an audit of an accredited supplier to validate the survey accreditation process of approved accreditation organizations in the TC of advanced diagnostic imaging services. The audits must be conducted on a representative sample of suppliers who have been accredited by a particular accrediting organization or in response to allegations of supplier noncompliance with the standards. When conducted on a representative sample basis, we are proposing that the audit would be comprehensive and address all of the standards or would focus on a specific standard in issue. When conducted in response to an allegation, we would specify that the CMS team or our contractor would audit for any standard that we determined was related to the allegations. At the conclusion of this audit, if CMS identifies any accreditation programs for which validation audit results indicate—

(i) A 10 percent rate of disparity between findings by the accreditation organization and findings by CMS or its designated survey team on standards that do not constitute immediate jeopardy to patient health and safety if unmet.

(ii) Any disparity between findings by the accreditation organization and

findings by CMS on standards that constitute immediate jeopardy to patient health and safety if unmet.

(iii) That, irrespective of the rate of disparity, there are widespread or systemic problems in an organization's accreditation process such that accreditation by that accreditation organization no longer provides CMS with adequate assurance that suppliers meet or exceed the Medicare requirements.

(2) *Notice of intent to withdraw approval.* CMS provides the organization written notice of its intent to withdraw approval if an equivalency review, validation review, onsite observation, or CMS' daily experience with the accreditation organization suggests that the accreditation organization is not meeting the requirements of this section.

(3) *Withdrawal of approval.* CMS may withdraw its approval of an accreditation organization at any time if CMS determines that—

(i) Accreditation by the organization no longer adequately assures that the suppliers furnishing the technical component of advanced diagnostic imaging service are meeting the established industry standards for each modality and that failure to meet those requirements could jeopardize the health or safety of Medicare beneficiaries and could constitute a significant hazard to the public health; or

(ii) The accreditation organization has failed to meet its obligations with respect to application or reapplication procedures.

(f) *Reconsideration.* An accreditation organization dissatisfied with a determination that its accreditation requirements do not provide or do not continue to provide reasonable assurance that the suppliers accredited by the accreditation organization meet the applicable quality standards is entitled to a reconsideration. CMS reconsiders any determination to deny, remove, or not renew the approval of designation to accreditation organizations if the accreditation organization files a written request for reconsideration by its authorized officials or through its legal representative.

(1) *Filing requirements.*

(i) The request must be filed within 30 calendar days of the receipt of CMS notice of an adverse determination or non renewal.

(ii) The request for reconsideration must specify the findings or issues with which the accreditation organization disagrees and the reasons for the disagreement.

(iii) A requestor may withdraw its request for reconsideration at any time before the issuance of a reconsideration determination.

(2) *CMS response to a filing request.* In response to a request for reconsideration, CMS provides the accreditation organization with—

(i) The opportunity for an informal hearing to be conducted by a hearing officer appointed by the Administrator of CMS and provide the accreditation organization the opportunity to present, in writing and in person, evidence or documentation to refute the determination to deny approval, or to withdraw or not renew designation; and

(ii) Written notice of the time and place of the informal hearing at least 10 business days before the scheduled date.

(3) *Hearing requirements and rules.*

(i) The informal reconsideration hearing is open to all of the following:

(A) CMS.

(B) The organization requesting the reconsideration including—

(*1*) Authorized representatives;

(*2*) Technical advisors (individuals with knowledge of the facts of the case or presenting interpretation of the facts); and

(*3*) Legal counsel.

(ii) The hearing is conducted by the hearing officer who receives testimony and documents related to the proposed action.

(iii) Testimony and other evidence may be accepted by the hearing officer even though it is inadmissible under the rules of court procedures.

(iv) The hearing officer does not have the authority to compel by subpoena the production of witnesses, papers, or other evidence.

(v) Within 45 calendar days of the close of the hearing, the hearing officer presents the findings and recommendations to the accreditation organization that requested the reconsideration.

(vi) The written report of the hearing officer includes separate numbered findings of fact and the legal conclusions of the hearing officer.

(vii) The hearing officer's decision is final.

Subpart F—Competitive Bidding for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

16. Section 414.402 is amended by revising the definition ''Grandfathered item'' to read as follows:

§ 414.402 Definitions.

* * * * *

Grandfathered Item means all rented items within a product category for which payment was made prior to the implementation of a competitive bidding program to a grandfathered supplier that chooses to continue to furnish the items in accordance with § 414.408(j) of this subpart and that fall within the following payment categories for competitive bidding:

(1) An inexpensive or routinely purchased item described in § 414.220 of this part.

(2) An item requiring frequent and substantial servicing, as described in § 414.222 of this part.

(3) Oxygen and oxygen equipment described in § 414.226 of this part.

(4) Other DME described in § 414.229 of this part.

* * * * *

17. Section 414.408 is amended by—

(A) Redesignating paragraph (j)(5) as (j)(7).

(B) Adding a new paragraphs (j)(5) and (j)(6).

§ 414.408 Payment rules.

* * * * *

(j) * * *

(5) *Notification of beneficiaries and CMS by suppliers that choose to become grandfathered suppliers.*

(i) *Notification of beneficiaries by suppliers.*

(A) *Requirements of notification.* A noncontract supplier that elects to become a grandfathered supplier must provide a 30-day written notification to each Medicare beneficiary that resides in a competitive bidding area and is currently renting a competitively bid item from that supplier. The 30-day notification to the beneficiary must meet the following requirements:

(*1*) Be sent by the supplier to the beneficiary at least 30 business days before the start date of the implementation of the competitive bidding program for the CBA in which the beneficiary resides.

(*2*) Identify the grandfathered items that the supplier is willing to continue to rent to the beneficiary.

(*3*) Be in writing (for example, by letter or postcard) and the supplier must maintain proof of delivery.

(*4*) State that the supplier is willing to continue to furnish certain rented Durable Medical Equipment (DME), oxygen and oxygen equipment, and supplies that the supplier is currently furnishing to the beneficiary (that is, before the start of the competitive bidding program) and is willing to continue to provide these items to the beneficiary for the remaining rental months.

(*5*) State that the beneficiary has the choice to continue to receive a grandfathered item(s) from the

grandfathered supplier or may elect to receive the item(s) from a contract supplier after the end of the last month for which a rental payment is made to the noncontract supplier.

(*6*) Provide the supplier's telephone number and instruct the beneficiary to call the supplier with any questions and to notify the supplier of his or her decision to use or not use the supplier as a grandfathered supplier.

(*7*) State that the beneficiary can obtain information about the competitive bidding program by calling 1–800–MEDICARE or accessing *http://www.medicare.gov* on the Internet.

(B) *Record of beneficiary's choice.* The supplier should obtain an election from the beneficiary regarding whether to use or not use the supplier as a grandfathered supplier. The supplier must maintain a record of its attempts to communicate with the beneficiary to obtain the beneficiary's election regarding grandfathering. When the suppier obtains such an election, the supplier must maintain a record of the beneficiary decision including the date the choice was made, and how the beneficiary communicated his or her choice to the supplier.

(C) *Notification.* If the beneficiary chooses not to continue to receive a grandfathered item(s) from their current supplier, the supplier must provide the beneficiary with 2 more notices in addition to the 30-day notice prior to the supplier picking up its equipment.

(*1*) *10-day notification:* Ten business days prior to picking up the item, the supplier should have direct contact (for example, a phone call) with the beneficiary or the beneficiary's caregiver and receive acknowledgement that the beneficiary understands their equipment will be picked up. This should occur on the first anniversary date after the start of the CBP or on another date agreed to by the beneficiary or the beneficiary's caregiver. The beneficiary's anniversary date occurs every month and is the date of the month on which the item was first delivered to the beneficiary by the current supplier. When a date other than the anniversary date is chosen by the beneficiary or the beneficiary's caregiver, the noncontract supplier will still receive payment up to the anniversary date after the start of the CBP, and the new contract supplier may not bill for any period of time before the anniversary date.

(*2*) *2-day notification:* Two business days prior to picking up the item the supplier should contact the beneficiary of the beneficiary's caregiver by phone to notify the beneficiary of the date the supplier will pick up the item. This date should not be before the beneficiary's first anniversary date that occurs after the start of the competitive bidding program unless an alternative arrangement has been made with the beneficiary and the new contract supplier.

(D) *Pickup procedures.*

(*1*) The pickup of the noncontract supplier's equipment and the delivery of the new contract supplier's equipment should occur on the same date, that is, the first rental anniversary date of the equipment that occurs after the start of the competitive bidding program unless an alternative arrangement has been made with the beneficiary and the new contract supplier.

(*2*) Under no circumstance should a supplier pick up a rented item prior to the supplier's receiving acknowledgement from the beneficiary that the beneficiary is aware of the date on which the supplier is picking up the item and the beneficiary has made arrangements to have the item replaced on that date by a contract supplier.

(*3*) When a beneficiary chooses to switch to a new contract supplier, the current noncontract supplier and the new contract supplier must make arrangements that are suitable to the beneficiary.

(*4*) The contract supplier may not submit a claim with a date of delivery for the new equipment that is prior to the first anniversary date that occurs after the beginning of the CBP, and the contract supplier may not begin billing until the first anniversary date that occurs after the beginning of the CBP.

(*5*) The noncontract supplier must submit a claim to be paid up to the first anniversary date that occurs after the beginning of the CBP. Therefore, they should not pick up the equipment before that date unless an alternative arrangement has been made with the beneficiary and the new contract supplier.

(ii) *Notification to CMS by suppliers.* A noncontract supplier that elects to become a grandfathered supplier must provide a written notification to CMS of this decision. This notification must meet the following requirements:

(A) State that the supplier agrees to continue to furnish certain rented DME, oxygen and oxygen equipment that it is currently furnishing to beneficiaries (that is, before the start of the competitive bidding program) in a CBA and will continue to provide these items to these beneficiaries for the remaining months of the rental period.

(B) Include the following information:

(*1*) Name and address of the supplier.

(*2*) The 6-digit NSC number of the supplier.

(*3*) Product category(s) by CBA for which the supplier is willing to be a grandfathered supplier.

(C) State that the supplier agrees to meet all the terms and conditions pertaining to grandfathered suppliers.

(D) Be provided by the supplier to CMS in writing at least 30 business days before the start date of the implementation of the Medicare DMEPOS Competitive Bidding Program.

(*6*) *Suppliers that choose not to become grandfathered suppliers.*

(i) *Requirement for non-grandfathered supplier.* A noncontract supplier that elects not to become a grandfathered supplier is required to pick up the item it is currently renting to the beneficiary from the beneficiary's home after proper notification.

(ii) *Notification.* Proper notification includes a 30-day, a 10-day, and a 2-day notice of the supplier's decision not to become a grandfathered supplier to its Medicare beneficiaries who are currently renting certain DME competitively bid item(s) and who reside in a CBA.

(iii) *Requirements of notification.* These notifications must meet all of the requirements listed in paragraph (j)(5)(i) of this section for the 30-day, 10-day and 2-day notices that must be sent by suppliers who decide to be grandfathered suppliers, with the following exceptions for the 30-day notice.

(A) State that, for those items for which the supplier has decided not to be a grandfathered supplier, the supplier will only continue to rent these competitively bid item(s) to its beneficiaries up to the first anniversary date that occurs after the start of the Medicare DMEPOS Competitive Bidding Program.

(B) State that the beneficiary must select a contract supplier for Medicare to continue to pay for these items.

(C) Refer the beneficiary to the contract supplier locator tool on *http://www.medicare.gov* and to 1–800–MEDICARE to obtain information about the availability of contract suppliers for the beneficiary's area.

(iv) *Pickup procedures.*

(A) The pick-up of the noncontract supplier's equipment and the delivery of the new contract supplier's equipment should occur on the same date, that is, the first rental anniversary date of the equipment that occurs after the start of the competitive bidding program unless an alternative arrangement has been made with the beneficiary and the new contract supplier.

(B) Under no circumstance should a supplier pick up a rented item prior to the supplier's receiving acknowledgement from the beneficiary that the beneficiary is aware of the date on which the supplier is picking up the item and the beneficiary has made arrangements to have the item replaced on that date by a contract supplier.

(C) When a beneficiary chooses to switch to a new contract supplier, the current noncontract supplier and the new contract supplier must make arrangements that are agreeable to the beneficiary.

(D) The contract supplier cannot submit a claim with a date of delivery for the new equipment that is prior to the first anniversary date that occurs after the beginning of the CBP.

* * * * *

18. Section 414.425 is added to read as follows:

§ 414.425 Claims for damages.

(a) *Eligibility for filing a claim for damages as a result of the termination of supplier contracts by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).* (1) Any aggrieved supplier, including a member of a network that was awarded a contract for the Round 1 Durable Medical Prosthetics, Orthotics, and Supplies Competitive Bidding Program (DMEPOS CBP) that believes it has been damaged by the termination of its competitive bid contract, may file a claim under this section.

(2) A subcontractor of a contract supplier is not eligible to submit a claim under this section.

(b) *Timeframe for filing a claim.* (1) A completed claim, including all documentation, must be filed within 90 days of the effective date of this paragraph, unless that day is a Federal holiday or Sunday in which case it will fall to the next business day.

(2) The date of filing is the actual date of receipt by the CBIC of a completed claim that includes all the information required by this rule.

(c) *Information that must be included in a claim.* (1) Supplier's name, name of authorized official, U.S. Post Office mailing address, phone number, e-mail address and bidding number, and National Supplier Clearinghouse Number;

(2) A copy of the signed contract entered into with CMS for the Round 1 DMEPOS Competitive Bidding Program;

(3) A detailed explanation of the damages incurred by this supplier as a direct result of the termination of the Round 1 competitive bid contract by MIPPA. The explanation must include all of the following:

(i) Documentation of the supplier's damages through receipts.

(ii) Records that substantiate the supplier's damages and demonstrate that the damages are directly related to performance of the Round 1 contract and are consistent with information the supplier provided as part of their bid.

(4) The supplier must explain how it would be damaged if not reimbursed.

(5) The claim must document steps the supplier took to mitigate any damages they may have incurred due to the contract termination, including a detailed explanation of the steps of all attempts to use for other purposes, return or dispose of equipment or other assets purchased or rented for the use in the Round 1 DMEPOS CBP contract performance.

(d) *Items that will not be considered in a claim.* The following items will not be considered in a claim:

(1) The cost of submitting a bid.

(2) Any fees or costs incurred for consulting or marketing.

(3) Costs associated with accreditation or licensure.

(4) Costs incurred before March 20, 2008.

(5) Costs incurred for contract performance after July 14, 2008 except for costs incurred to mitigate damages.

(6) Any profits a supplier may have expected from the contract.

(7) Costs that would have occurred without a contract having been awarded.

(8) Costs for items such as inventory, delivery vehicles, office space and equipment, personnel, which the supplier did not purchase specifically to perform the contract.

(9) Costs that the supplier has recouped by any means, and may include use of personnel, material, suppliers, or equipment in the supplier's business operations.

(e) *Filing a claim.* (1) A claim, with all supporting documentation, must be filed with the CMS Competitive Bidding Implementation Contractor (CBIC).

(2) Claims must include a statement from a supplier's authorized official certifying the accuracy of the information provided on the claim and all supporting documentation.

(3) The CBIC does not accept electronic submissions of claims for damages.

(f) *Review of claim.* (1) *Role of the CBIC.*

(i) The CBIC will review the claim to ensure it is submitted timely, complete, and by an eligible claimant. When the CBIC identifies that a claim is incomplete or not filed timely, it will make a recommendation to the Determining Authority not to process the claim further. Incomplete or untimely claims may be dismissed by the Determining Authority without further processing.

(ii) For complete, timely claims, the CBIC will review the claim on its merits to determine if damages are warranted and may seek further information from the claimant when making its recommendation to the Determining Authority. The CBIC may set a deadline for receipt of additional information. A claimant's failure to respond timely may result in a denial of the claim.

(iii) The CBIC will make a recommendation to the Determining Authority for each claim filed and include an explanation that supports its recommendation.

(iv) The recommendation must be either to award damages for a particular amount (which may not be the same amount requested by the claimant) or that no damages should be awarded.

(A) If the CBIC recommends that damages are warranted, the CBIC will calculate a recommended reasonable amount of damages based on the claim submitted.

(B) The reasonable amount will consider both costs incurred and the contractor's attempts and action to limit the damages;

(v) The recommendation will be sent to the Determining Authority for a final determination.

(2) *CMS' role as the Determining Authority*.

(i) The Determining Authority shall review the recommendation of the CBIC.

(ii) The Determining Authority may seek further information from the claimant or the CBIC in making a concurrence or non-concurrence determination.

(iii) The Determining Authority may set a deadline for receipt of additional information. A claimant's failure to respond timely may result in a denial of the claim.

(iv) If the Determining Authority concurs with the CBIC recommendation, the Determining Authority shall submit a final signed decision to the CBIC and direct the CBIC to notify the claimant of the decision and the reasons for the final decision.

(v) If the Determining Authority non-concurs with the CBIC recommendation, the Determining Authority may return the claim for further processing or the Determining Authority may:

(A) Write a determination granting (in whole or in part) a claim for damages or denying a claim in its entirety;

(B) Direct the CBIC to write said determination for the Determining Authority's signature; or

(C) Return the claim to the CBIC with further instructions.

(vi) The Determining Authority's determination is final and not subject to administrative or judicial review.

(g) *Timeframe for determinations.* (1) Every effort will be made to make a determination within 120 days of initial receipt of the claim for damages by the CBIC or the receipt of additional information that was requested by the CBIC, whichever is later.

(2) In the case of more complex cases, or in the event of a large workload, a decision will be issued as soon as practicable.

(h) *Notification to claimant of damage determination.* The CBIC must mail the Determining Authority's determination to the claimant by certified mail return receipt requested, at the address provided in the claim.

Subpart H—Fee Schedule for Ambulance Services

19. Section 414.610 is amended by revising paragraph (c)(5)(i) to read as follows:

§ 414.610 Basis of payment.

* * * * *

(c) * * *

(5) * * *

(i) For ground ambulance services where the point of pickup is in a rural area, the mileage rate is increased by 50 percent for each of the first 17 miles and, for services furnished before January 1, 2004, by 25 percent for miles 18 through 50. The standard mileage rate applies to every mile over 50 miles and, for services furnished after December 31, 2003, to every mile over 17 miles. For air ambulance services where the point of pickup is in a rural area, the total payment is increased by 50 percent; that is, the rural adjustment factor applies to the sum of the base rate and the mileage rate.

* * * * *

Subpart J—Submission of Manufacturer's Average Sales Price Data

20. Section 414.802 is amended by revising the definition of ''unit'' to read as follows:

§ 414.802 Definitions.

* * * * *

Unit means the product represented by the 11-digit National Drug Code. The method of counting units excludes units of CAP drugs (as defined in § 414.902) sold to an approved CAP vendor (as defined in § 414.902) for use under the CAP (as defined in § 414.902).

Subpart K—Payment for Drugs and Biologicals Under Part B

§ 414.904 [Amended]

21. Amend § 414.904(d)(3) by removing the phrase ''and 2009'' and adding in its place the phrase ''2009, and 2010.''

22. Section 414.906 is amended by—

B. Revising the introductory text of paragraph (c) and paragraph (c)(1).

C. Redesignating paragraph (c)(2) as (c)(3).

D. Adding new paragraph (c)(2).

E. Adding paragraphs (f)(2)(v), (f)(3)(iv), and (g).

The revision and additions read as follows:

§ 414.906 Competitive acquisition program as the basis for payment.

* * * * *

(c) *Computation of payment amount.* Except as specified in paragraph (c)(2) of this section, payment for CAP drugs is based on bids submitted as a result of the bidding process as described in § 414.910.

(1) *Single payment amount.*

(i) A single payment amount for each CAP drug in the competitive acquisition area is determined on the basis of the bids submitted and accepted and updated from the bidding period to the beginning of the payment year.

(ii) The single payment amount is then updated quarterly based on the approved CAP vendor's reasonable net acquisition costs for that category as determined by CMS, and limited by the weighted payment amount established under section 1847A of the Act across all drugs for which a composite bid is required in the category.

(iii) The payment amount for each other drug for which the approved CAP vendor submits a bid in accordance with § 414.910 of this subpart and each other drug that is approved by CMS for the approved CPA vendor to furnish under the CAP is also updated quarterly based on the approved CAP vendor's reasonable net acquisition costs for each HCPCS code and limited by the payment amount established under section 1847A of the Act.

(2) *Updates to payment amount.*

(i) The first update is effective on the first day of claims processing for the first quarter of an approved CAP vendor's contract. The first quarterly contract update is based on the reasonable net acquisition cost (RNAC) data reported to CMS or its designee for any purchases of drug before the beginning of CAP claims processing for the contract period and reported to CMS no later than 30 days before the beginning of CAP claims processing.

(ii) For subsequent quarters, each approved CAP vendor must report to CMS or its designee RNAC data for a quarter of CAP drug purchases within 30 days of the close of that quarter.

(iii) For all quarters, only RNAC data from approved CAP vendors that are supplying CAP drugs under their CAP contract at the time updates are being calculated must be used to calculate updated CAP payment amounts.

(iv) CMS excludes such RNAC data submitted by an approved CAP vendor if, during the time calculations are being done, CMS knows that the approved CAP vendor will not be under contract for the applicable quarterly update.

(v) The payment amount weights must be calculated based on the more recent of the following:

(A) Contract bidding weights.

(B) CAP claims data.

(vi) The payment limit must be determined using the most recent payment limits available to CMS under section 1847A of the Act.

(vii) The following payment amount update calculation must be applied for the group of all drugs for which a composite bid is required.

(A) The most recent previous composite payment amount for the group is updated by—

(*1*) Calculating the percent change in reasonable net acquisition costs for each approved CAP vendor;

(*2*) Calculating the median of all participating approved CAP vendors' adjusted CAP payment amounts; and

(*3*) Limiting the payment as described in paragraph (c)(1) of this section.

(B) The median percent change, subject to the limit described in paragraph (c)(1) of this section, must be the update percentage for that quarter.

(C) The single update percentage must be applied to the payment amount for each drug in the group of drugs for which a composite bid is required in the category.

(viii) The following payment amount update calculation must be applied for each of the following items: each HCPCS code not included in the composite bid list; each HCPCS code added to the drug list during the contract period; and each drug that has not yet been assigned a HCPCS code, but for which a HCPCS code will be established.

(A) The most recent previous payment amount for each drug must be updated by calculating the percent change in reasonable net acquisition costs for each approved CAP vendor, then calculating the median of all participating approved CAP vendors' adjusted CAP payment amounts.

(B) The median percent change calculated for each drug, subject to the

limit described in paragraph (c)(1) of this section, must be applied to the payment amount for each drug.

* * * * *

(f) * * *

(2) * * *

(v) On or after January 1, 2010, the proposed addition of drugs with similar therapeutic uses to drugs already supplied under the CAP by the approved CAP vendor(s).

(3) * * *

(iv) In the case of additions requested under paragraph (f)(2)(v) of this section, address and document the need for such an expansion based on demand for the product(s).

* * * * *

(g) Deletion of drugs on an approved CAP vendor's CAP drug list due to unavailability requires a written request and approval as described in paragraphs (f)(3)(i) through (iii) and (f)(4).

23. Section 414.908 is amended by revising paragraph (a)(3)(xii) to read as follows:

§ 414.908 Competitive acquisition program.

(a) * * *

(3) * * *

(xii) Agrees not to transport CAP drugs from one practice location or place of service to another location except in accordance with a written agreement between the participating CAP physician and the approved CAP vendor that requires that drugs are not subjected to conditions that will jeopardize their integrity, stability, and/or sterility while being transported.

* * * * *

24. Section 414.914 is amended by revising paragraph (f)(12) to read as follows:

§ 414.914 Terms of contract.

* * * * *

(f) * * *

(12) Supply CAP drugs upon receipt of a prescription order to all participating CAP physicians who have selected the approved CAP vendor, except when the conditions of paragraph (h) of this section or § 414.916(b) are met;

* * * * *

25. Section 414.916 is amended by —

A. Redesignating paragraph (b)(4) as (b)(5).

B. Adding new paragraph (b)(4).

The addition reads as follows:

§ 414.916 Dispute resolution for vendors and beneficiaries.

* * * * *

(b) * * *

(4) Upon notification from CMS of a participating CAP physician's suspension from the program, the approved CAP vendor must cease delivery of CAP drugs to the suspended participating CAP physician until the suspension has been lifted.

* * * * *

26. Section 414.917 is amended by revising paragraph (b)(4) to read as follows:

§ 414.917 Dispute resolution and process for suspension or termination of approved CAP contract and termination of physician participation under exigent circumstances.

* * * * *

(b) * * *

(4) The approved CAP vendor may appeal that termination by requesting a reconsideration. A determination must be made as to whether the approved CAP vendor has been meeting the service and quality obligations of its CAP contract. The approved CAP vendor's contract will remain suspended during the reconsideration process.

* * * * *

27. Section 414.930 is amended by—

A. Revising paragraph (a).

B. Redesignating paragraphs (b)(1)(v) as (vi).

C. Adding new paragraphs (b)(1)(v).

The revision and addition read as follows:

§ 414.930 Compendia for determination of medically-accepted indications for off-label uses of drugs and biologicals in an anti-cancer chemotherapeutic regimen.

(a) *Definitions.* For the purposes of this section:

Compendium means a comprehensive listing of FDA-approved drugs and biologicals or a comprehensive listing of a specific subset of drugs and biologicals in a specialty compendium, for example a compendium of anti-cancer treatment. A compendium—

(i) Includes a summary of the pharmacologic characteristics of each drug or biological and may include information on dosage, as well as recommended or endorsed uses in specific diseases.

(ii) Is indexed by drug or biological.

(iii) Has a publicly transparent process for evaluating therapies and for identifying potential conflicts of interests.

Publicly transparent process for evaluating therapies means that the following materials are available to the public on the compendium's Web site coincident with the compendium's publication of the related recommendation:

(i) The application for inclusion of a therapy including criteria used to evaluate the request.

(ii) A listing of all the evidentiary materials reviewed or considered by the compendium pursuant to the application.

(iii) A listing of all individuals who have substantively participated in the development of compendia recommendations.

(iv) Transcripts of meetings and records of the votes, including abstentions, related to the therapeutic recommendation on the application.

Publicly transparent process for identifying potential conflicts of interests means that the following materials are identified and available to the public coincident with the compendium's publication of the related recommendation:

(i) Direct or indirect financial relationships that exist between individuals who have substantively participated in the development of compendia recommendations and the applicant (for example, the manufacturer or seller of the drug or biological being reviewed by the compendium). This includes compensation arrangements such as salary, grant, contract, or collaboration agreements between individuals who have substantively participated in the development of compendia recommendations and the applicant.

(ii) Ownership or investment interests of individuals who have substantively participated in the development of compendia recommendations and the applicant (for example, the manufacturer or seller of the drug or biological being reviewed by the compendium).

(b) * * *

(1) * * *

(v) Considers whether the publication that is the subject of the request meets the definition of a compendium in this section.

* * * * *

PART 415—SERVICES FURNISHED BY PHYSICIANS IN PROVIDERS, SUPERVISING PHYSICIANS IN TEACHING SETTINGS, AND RESIDENTS IN CERTAIN SETTINGS

28. The authority citation for part 415 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395(hh)).

Subpart D—Physician Services in Teaching Settings

29. Section 415.178 is revised to read as follows:

§ 415.178 Anesthesia services.

(a) *General rule.* (1) *For services furnished prior to January 1, 2010*, an unreduced physician fee schedule payment may be made if a physician is involved in a single anesthesia procedure involving an anesthesia resident. In the case of anesthesia services, the teaching physician must be present during all critical portions of the procedure and immediately available to furnish services during the entire service or procedure. The teaching physician cannot receive an unreduced fee if he or she performs services involving other patients during the period the anesthesia resident is furnishing services in a single case. Additional rules for payment of anesthesia services involving residents are specified in § 414.46(c)(1)(iii) of this chapter.

(2) *For services furnished on or after January 1, 2010*, payment may be made under § 414.46(e) of this chapter if the teaching anesthesiologist is present during all critical or key portions of the anesthesia service or procedure involved; and the teaching anesthesiologist (or another anesthesiologist with whom the teaching anesthesiologist has entered into an arrangement) is immediately available to furnish anesthesia services during the entire procedure.

(b) *Documentation.* Documentation must indicate the physician's presence during all critical or key portions of the anesthesia procedure and the immediate availability of another teaching anesthesiologist.

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

30. The authority citation for part 485 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395(hh)).

Subpart B—Conditions of Participation: Comprehensive Outpatient Rehabilitation Facilities

31. Section 485.70 is amended by revising paragraph (j) to read as follows:

§ 485.70 Personnel qualifications.

* * * * *

(j) A respiratory therapist must complete one the following criteria:

(1) *Criterion 1.* All of the following must be completed:

(i) Be licensed by the State in which practicing, if applicable.

(ii) Have successfully completed a nationally-accredited educational program for respiratory therapists.

(iii)(A) Be eligible to take the registry examination administered by the National Board for Respiratory Care for respiratory therapists; or

(B) Have passed the registry examination administered by the National Board for Respiratory Care for respiratory therapists.

(2) *Criterion 2*: All of the following must be completed:

(i) Be licensed by the State in which practicing, if applicable.

(ii) Have equivalent training and experience as determined by the National Board for Respiratory Care.

* * * * *

Authority: Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program.

Dated: June 15, 2009.

Charlene Frizzera,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: June 30, 2009.

Kathleen Sebelius,

Secretary.

Note: These addenda will not appear in the Code of Federal Regulations.

Addendum A: Explanation and Use of Addenda B

The addenda on the following pages provide various data pertaining to the Medicare fee schedule for physicians' services furnished in CY 2010. Addendum B contains the RVUs for work, nonfacility PE, facility PE, and malpractice expense, and other information for all services included in the PFS.

In previous years, we have listed many services in Addendum B that are not paid under the PFS. To avoid publishing as many pages of codes for these services, we are not including clinical laboratory codes or the alphanumeric codes (Healthcare Common Procedure Coding System (HCPCS) codes not included in CPT) not paid under the PFS in Addendum B.

Addendum B contains the following information for each CPT code and alphanumeric HCPCS code, except for: Alphanumeric codes beginning with B (enteral and parenteral therapy), E (durable medical equipment), K (temporary codes for nonphysicians' services or items), or L (orthotics); and codes for anesthesiology. Please also note the following:

- An ''NA'' in the ''Non-facility PE RVUs'' column of Addendum B means that CMS has not developed a PE RVU in the nonfacility setting for the service because it is typically performed in the hospital (for example, an open heart surgery is generally performed in the hospital setting and not a physician's office). If there is an ''NA'' in the nonfacility PE RVU column, and the contractor determines that this service can be performed in the nonfacility setting, the service will be paid at the facility PE RVU rate.
- Services that have an ''NA'' in the ''Facility PE RVUs'' column of Addendum B are typically not paid using the PFS when provided in a facility setting. These services (which include ''incident to'' services and the technical portion of diagnostic tests) are generally paid under either the outpatient hospital prospective payment system or bundled into the hospital inpatient prospective payment system payment.

1. *CPT/HCPCS code.* This is the CPT or alphanumeric HCPCS number for the service. Alphanumeric HCPCS codes are included at the end of this addendum.

2. *Modifier.* A modifier is shown if there is a technical component (modifier TC) and a professional component (PC) (modifier-26) for the service. If there is a PC and a TC for the service, Addendum B contains three entries for the code. A code for: The global values (both professional and technical); modifier-26 (PC); and, modifier TC. The global service is not designated by a modifier, and physicians must bill using the code without a modifier if the physician furnishes both the PC and the TC of the service.

Modifier-53 is shown for a discontinued procedure, for example a colonoscopy that is not completed. There will be RVUs for a code with this modifier.

3. *Status indicator.* This indicator shows whether the CPT/HCPCS code is in the PFS and whether it is separately payable if the service is covered.

A = Active code. These codes are separately payable under the PFS if covered. There will be RVUs for codes with this status. The presence of an ''A'' indicator does not mean that Medicare has made a national coverage determination regarding the service. Carriers remain responsible for coverage decisions in the absence of a national Medicare policy.

B = Bundled code. Payments for covered services are always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident (an example is a telephone call from a hospital nurse regarding care of a patient).

C = Carriers price the code. Carriers will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation, such as an operative report.

D = Deleted/discontinued code.*

E = Excluded from the PFS by regulation. These codes are for items and services that CMS chose to exclude from the fee schedule payment by regulation. No RVUs are shown, and no payment may be made under the PFS for these codes. Payment for them, when covered, continues under reasonable charge procedures.

F = Deleted/discontinued codes. (Code not subject to a 90-day grace period.) These codes are deleted effective with the beginning of the year and are never subject to a grace period. This indicator is no longer effective beginning with the 2005 fee schedule as of January 1, 2005.

G = Code not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. (Codes

subject to a 90-day grace period.) This indicator is no longer effective with the 2005 PFS as of January 1, 2005.

H* = Deleted modifier. For 2000 and later years, either the TC or PC component shown for the code has been deleted and the deleted component is shown in the database with the H status indicator.

I = Not valid for Medicare purposes. Medicare uses another code for the reporting of, and the payment for these services. (Codes not subject to a 90-day grace period.)

L = Local codes. Carriers will apply this status to all local codes in effect on January 1, 1998 or subsequently approved by central office for use. Carriers will complete the RVUs and payment amounts for these codes.

M = Measurement codes, used for reporting purposes only. There are no RVUs and no payment amounts for these codes. Medicare uses them to aid with performance measurement. No separate payment is made. These codes should be billed with a zero (($0.00) charge and are denied) on the MPFSDB.

N = Non-covered service. These codes are non-covered services. Medicare payment may not be made for these codes. If RVUs are shown, they are not used for Medicare payment.

R = Restricted coverage. Special coverage instructions apply. If the service is covered and no RVUs are shown, it is carrier-priced.

T = There are RVUs for these services, but they are only paid if there are no other services payable under the PFS billed on the same date by the same provider. If any other services payable under the PFS are billed on the same date by the same provider, these services are bundled into the service(s) for which payment is made.

X = Statutory exclusion. These codes represent an item or service that is not within the statutory definition of ''physicians' services'' for PFS payment purposes. No RVUs are shown for these codes, and no payment may be made under the PFS. (Examples are ambulance services and clinical diagnostic laboratory services.)

4. *Description of code.* This is an abbreviated version of the narrative description of the code.

5. *Physician work RVUs.* These are the RVUs for the physician work for this service in CY 2010.

6. *Nonfacility practice expense RVUs.* These are the 2010 resource-based PE RVUs for nonfacility settings.

7. *Facility practice expense RVUs.* These are the 2010 resource-based PE RVUs for facility settings.

8. *Malpractice expense RVUs.* These are the RVUs for the malpractice expense for the service for 2010.

Note: The budget neutrality reduction resulting from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941 and 98942. The required reduction will only be reflected in the files used for Medicare payment.

9. *Global period.* This indicator shows the number of days in the global period for the code (0, 10, or 90 days). An explanation of the alpha codes follows:

MMM = Code describes a service furnished in uncomplicated maternity cases including antepartum care, delivery, and postpartum care. The usual global surgical concept does not apply. *See* the 1999 Physicians' Current Procedural Terminology for specific definitions.

XXX = The global concept does not apply.

YYY = The global period is to be set by the carrier (for example, unlisted surgery codes).

ZZZ = Code related to another service that is always included in the global period of the other service. (**Note:** Physician work and PE are associated with intra service time and in some instances in the post service time.

*Codes with these indicators had a 90-day grace period before January 1, 2005.

BILLING CODE 4210–01–P

ADDENDUM B: Proposed Relative Value Units and Related Information Used in Determining Medicare Payments for CY 2010

CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
0016T		C	Thermotx choroid vasc lesion	0.00	0.00	0.00	0.00	XXX
0017T		C	Photocoagulat macular drusen	0.00	0.00	0.00	0.00	XXX
0019T		C	Extracorp shock wv tx,ms nos	0.00	0.00	0.00	0.00	XXX
0030T		C	Antiprothrombin antibody	0.00	0 00	0.00	0.00	XXX
0042T		C	Ct perfusion w/contrast, cbf	0.00	0.00	0.00	0.00	XXX
0048T		C	Implant ventricular device	0.00	0.00	0.00	0.00	XXX
0050T		C	Removal circulation assist	0.00	0.00	0.00	0.00	XXX
0051T		C	Implant total heart system	0.00	0.00	0.00	0.00	XXX
0052T		C	Replace component heart syst	0.00	0.00	0.00	0.00	XXX
0053T		C	Replace component heart syst	0.00	0.00	0.00	0.00	XXX
0054T		C	Bone surgery using computer	0.00	0.00	0.00	0.00	XXX
0055T		C	Bone surgery using computer	0.00	0.00	0.00	0.00	XXX
0064T		C	Spectroscop eval expired gas	0.00	0.00	0.00	0 00	XXX
0067T		C	Ct colonography;dx	0.00	0.00	NA	0.00	XXX
0067T	TC	C	Ct colonography;dx	0.00	0.00	NA	0.00	XXX
0067T	26	C	Ct colonography;dx	0.00	0 00	0.00	0.00	XXX
0068T		C	Interp/rept heart sound	0.00	0.00	0.00	0.00	XXX
0069T		C	Analysis only heart sound	0.00	0.00	0.00	0.00	XXX
0070T		C	Interp only heart sound	0.00	0.00	0.00	0.00	XXX
0071T		C	U/s leiomyomata ablate <200	0.00	0.00	0.00	0.00	XXX
0072T		C	U/s leiomyomata ablate >200	0.00	0.00	0.00	0.00	XXX
0073T		A	Delivery, comp imrt	0.00	7.98	NA	0 00	XXX
0075T		C	Perq stent/chest vert art	0.00	0.00	NA	0.00	XXX
0075T	TC	C	Perq stent/chest vert art	0.00	0.00	NA	0.00	XXX
0075T	26	C	Perq stent/chest vert art	0.00	0.00	0.00	0.00	XXX
0076T		C	S&s stent/chest vert art	0.00	0.00	NA	0.00	XXX
0076T	TC	C	S&s stent/chest vert art	0.00	0.00	NA	0 00	XXX
0076T	26	C	S&s stent/chest vert art	0.00	0.00	0.00	0.00	XXX
0077T		C	Cereb therm perfusion probe	0.00	0.00	0.00	0.00	XXX
0078T		C	Endovasc aort repr w/device	0.00	0.00	0.00	0.00	XXX
0079T		C	Endovasc visc extnsn repr	0.00	0.00	0.00	0.00	XXX
0080T		C	Endovasc aort repr rad s&s	0.00	0.00	0.00	0.00	XXX
0081T		C	Endovasc visc extnsn s&s	0.00	0.00	0.00	0.00	XXX
0084T		C	Temp prostate urethral stent	0.00	0.00	0.00	0.00	XXX
0086T		C	L ventricle fill pressure	0.00	0.00	0.00	0.00	XXX
0087T		C	Sperm eval hyaluronan	0.00	0.00	0.00	0 00	XXX
0092T		C	Artific disc addl	0.00	0.00	0.00	0.00	XXX

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[4] Global totals for malpractice RVUs may not sum due to rounding.

CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
0095T		C	Artific diskectomy addl	0.00	0.00	0.00	0.00	XXX
0098T		C	Rev artific disc addl	0.00	0 00	0.00	0.00	XXX
0099T		C	Implant corneal ring	0.00	0 00	0.00	0.00	XXX
0100T		C	Prosth retina receive&gen	0 00	0 00	0.00	0.00	XXX
0101T		C	Extracorp shockwv tx,hi enrg	0.00	0.00	0.00	0.00	XXX
0102T		C	Extracorp shockwv tx,anesth	0.00	0.00	0.00	0.00	XXX
0103T		C	Holotranscobalamin	0.00	0.00	0.00	0.00	XXX
0104T		C	At rest cardio gas rebreathe	0.00	0.00	0.00	0.00	XXX
0105T		C	Exerc cardio gas rebreathe	0.00	0.00	0 00	0.00	XXX
0106T		C	Touch quant sensory test	0 00	0.00	0 00	0.00	XXX
0107T		C	Vibrate quant sensory test	0.00	0.00	0.00	0.00	XXX
0108T		C	Cool quant sensory test	0.00	0.00	0 00	0.00	XXX
0109T		C	Heat quant sensory test	0.00	0.00	0.00	0.00	XXX
0110T		C	Nos quant sensory test	0.00	0.00	0.00	0.00	XXX
0111T		C	Rbc membranes fatty acids	0.00	0.00	0 00	0.00	XXX
0123T		C	Scleral fistulization	0.00	0.00	0.00	0.00	XXX
0124T		C	Conjunctival drug placement	0.00	0.00	0.00	0 00	XXX
0126T		C	Chd risk imt study	0.00	0.00	0.00	0.00	XXX
0130T		C	Chron care drug investigatn	0.00	0.00	0.00	0.00	XXX
0140T		C	Exhaled breath condensate ph	0.00	0.00	0 00	0.00	XXX
0141T		I	Perq islet transplant	0.00	0.00	0.00	0.00	XXX
0142T		I	Open islet transplant	0.00	0.00	0.00	0.00	XXX
0143T		I	Laparoscopic islet transplnt	0.00	0.00	0.00	0.00	XXX
0144T		C	CT heart wo dye; qual calc	0.00	0.00	NA	0.00	XXX
0144T	TC	C	CT heart wo dye; qual calc	0.00	0.00	NA	0.00	XXX
0144T	26	C	CT heart wo dye; qual calc	0.00	0.00	0.00	0.00	XXX
0145T		C	CT heart w/wo dye funct	0.00	0.00	NA	0.00	XXX
0145T	TC	C	CT heart w/wo dye funct	0.00	0.00	NA	0.00	XXX
0145T	26	C	CT heart w/wo dye funct	0.00	0.00	0.00	0.00	XXX
0146T		C	CCTA w/wo dye	0.00	0.00	NA	0.00	XXX
0146T	TC	C	CCTA w/wo dye	0.00	0.00	NA	0.00	XXX
0146T	26	C	CCTA w/wo dye	0.00	0.00	0.00	0.00	XXX
0147T		C	CCTA w/wo, quan calcium	0 00	0.00	NA	0.00	XXX
0147T	TC	C	CCTA w/wo, quan calcium	0.00	0.00	NA	0.00	XXX
0147T	26	C	CCTA w/wo, quan calcium	0.00	0.00	0.00	0.00	XXX
0148T		C	CCTA w/wo, strxr	0.00	0.00	NA	0.00	XXX
0148T	TC	C	CCTA w/wo, strxr	0.00	0.00	NA	0.00	XXX
0148T	26	C	CCTA w/wo, strxr	0 00	0.00	0.00	0.00	XXX
0149T		C	CCTA w/wo, strxr quan calc	0.00	0.00	NA	0.00	XXX
0149T	TC	C	CCTA w/wo, strxr quan calc	0.00	0.00	NA	0.00	XXX
0149T	26	C	CCTA w/wo, strxr quan calc	0.00	0.00	0.00	0.00	XXX
0150T		C	CCTA w/wo, disease strxr	0.00	0.00	NA	0.00	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
0150T	TC	C	CCTA w/wo, disease strxr	0 00	0.00	NA	0.00	XXX
0150T	26	C	CCTA w/wo, disease strxr	0.00	0.00	0 00	0.00	XXX
0151T		C	CT heart funct add-on	0.00	0 00	NA	0 00	XXX
0151T	TC	C	CT heart funct add-on	0.00	0.00	NA	0 00	XXX
0151T	26	C	CT heart funct add-on	0 00	0.00	0.00	0.00	XXX
0155T		C	Lap impl gast curve electrd	0.00	0.00	0.00	0.00	XXX
0156T		C	Lap remv gast curve electrd	0.00	0.00	0.00	0.00	XXX
0157T		C	Open impl gast curve electrd	0.00	0.00	0.00	0 00	XXX
0158T		C	Open remv gast curve electrd	0.00	0.00	0.00	0.00	XXX
0159T		C	Cad breast mri	0.00	0.00	NA	0.00	ZZZ
0159T	TC	C	Cad breast mri	0.00	0 00	NA	0.00	ZZZ
0159T	26	C	Cad breast mri	0.00	0 00	0.00	0.00	ZZZ
0160T		C	Tcranial magn stim tx plan	0.00	0.00	0 00	0.00	XXX
0161T		C	Tcranial magn stim tx deliv	0.00	0.00	0 00	0.00	XXX
0163T		C	Lumb artif diskectomy addl	0.00	0.00	0 00	0.00	YYY
0164T		C	Remove lumb artif disc addl	0.00	0.00	0.00	0.00	YYY
0165T		C	Revise lumb artif disc addl	0.00	0.00	0 00	0.00	YYY
0166T		C	Tcath vsd close w/o bypass	0.00	0.00	0.00	0.00	XXX
0167T		C	Tcath vsd close w bypass	0 00	0.00	0.00	0.00	XXX
0168T		C	Rhinophototx light app bilat	0 00	0.00	0.00	0.00	XXX
0169T		C	Place stereo cath brain	0.00	0.00	0 00	0.00	XXX
0170T		C	Anorectal fistula plug rpr	0.00	0.00	0.00	0.00	XXX
0171T		C	Lumbar spine proces distract	0.00	0.00	0.00	0.00	XXX
0172T		C	Lumbar spine process addl	0.00	0.00	0.00	0.00	XXX
0173T		C	Iop monit io pressure	0.00	0.00	0.00	0.00	XXX
0174T		C	Cad cxr with interp	0.00	0.00	0.00	0.00	XXX
0175T		C	Cad cxr remote	0.00	0.00	0.00	0.00	XXX
0176T		C	Aqu canal dilat w/o retent	0.00	0.00	0.00	0.00	XXX
0177T		C	Aqu canal dilat w retent	0.00	0.00	0.00	0.00	XXX
0178T		C	64 lead ecg w i&r	0.00	0.00	0 00	0.00	XXX
0179T		C	64 lead ecg w tracing	0.00	0.00	0.00	0.00	XXX
0180T		C	64 lead ecg w i&r only	0.00	0.00	0.00	0.00	XXX
0181T		C	Corneal hysteresis	0.00	0.00	0.00	0.00	XXX
0182T		C	Hdr elect brachytherapy	0.00	0.00	0.00	0.00	XXX
0183T		C	Wound ultrasound	0.00	0.00	0.00	0.00	XXX
0184T		C	Exc rectal tumor endoscopic	0.00	0.00	0.00	0.00	XXX
0185T		C	Comptr probability analysis	0.00	0.00	0.00	0.00	XXX
0186T		C	Suprachoroidal drug delivery	0.00	0.00	0.00	0.00	XXX
0187T		C	Ophthalmic dx image anterior	0.00	0.00	0.00	0.00	XXX
0190T		C	Place intraoc radiation src	0.00	0.00	0.00	0.00	XXX
0191T		C	Insert ant segment drain int	0.00	0.00	0.00	0 00	XXX
0192T		C	Insert ant segment drain ext	0.00	0.00	0.00	0.00	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
0193T		C	Rf bladder neck microremodel	0.00	0.00	0 00	0 00	XXX
0194T		C	Procalcitonin (pct)	0.00	0.00	0 00	0.00	XXX
0195T		C	Arthrod presac interbody	0.00	0.00	0.00	0.00	XXX
0196T		C	Arthrod presac interbody eac	0.00	0.00	0 00	0.00	XXX
0197T		C	Intrafraction track motion	0.00	0.00	0 00	0.00	XXX
0198T		C	Ocular blood flow measure	0.00	0.00	0.00	0.00	XXX
0528F		I	Rcmnd flw-up 10 yrs docd	0.00	0.00	0.00	0.00	XXX
0535F		I	Dyspnea mngmnt plan docd	0.00	0.00	0.00	0.00	XXX
0575F		I	HIV rna plan care docd	0 00	0.00	0.00	0.00	XXX
10021		A	Fna w/o image	1.27	2.33	0.52	0.11	XXX
10022		A	Fna w/image	1.27	2.09	0 42	0.09	XXX
10040		A	Acne surgery	1 19	1.36	1 05	0.07	010
10060		A	Drainage of skin abscess	1.19	1.69	1 22	0.08	010
10061		A	Drainage of skin abscess	2.42	2.32	1 71	0.19	010
10080		A	Drainage of pilonidal cyst	1.19	3.08	1 33	0.11	010
10081		A	Drainage of pilonidal cyst	2.47	4.19	1.85	0.28	010
10120		A	Remove foreign body	1.23	2.29	1.14	0.09	010
10121		A	Remove foreign body	2.71	4.05	1.95	0.28	010
10140		A	Drainage of hematoma/fluid	1.55	2.49	1 43	0.14	010
10160		A	Puncture drainage of lesion	1.22	2.03	1 20	0 11	010
10180		A	Complex drainage, wound	2.27	3.74	2.12	0.34	010
11000		A	Debride infected skin	0.60	0.78	0.17	0.04	000
11001		A	Debride infected skin add-on	0.30	0 25	0.09	0.02	ZZZ
11004		A	Debride genitalia & perineum	10.80	NA	3.91	1.40	000
11005		A	Debride abdom wall	14 24	NA	5.35	2.21	000
11006		A	Debride genit/per/abdom wall	13.10	NA	4.82	1.72	000
11008		A	Remove mesh from abd wall	5.00	NA	1.88	0.79	ZZZ
11010		A	Debride skin, fx	4.19	8.01	2.91	0.56	010
11011		A	Debride skin/muscle, fx	4.94	8.21	2.63	0.70	000
11012		A	Debride skin/muscle/bone, fx	6.87	10.64	3.89	0.99	000
11040		A	Debride skin, partial	0.50	0.73	0 16	0.03	000
11041		A	Debride skin, full	0.60	0.78	0 20	0.04	000
11042		A	Debride skin/tissue	0.80	1.09	0.29	0.07	000
11043		A	Debride tissue/muscle	3.04	4.10	3.08	0.34	010
11044		A	Debride tissue/muscle/bone	4.11	5.72	4.28	0.53	010
11055		R	Trim skin lesion	0.43	0.86	0 11	0.02	000
11056		R	Trim skin lesions, 2 to 4	0.61	0.93	0.15	0.03	000
11057		R	Trim skin lesions, over 4	0.79	1.04	0.19	0.04	000
11100		A	Biopsy, skin lesion	0.81	1.77	0.48	0.05	000
11101		A	Biopsy, skin add-on	0.41	0.43	0.24	0.02	ZZZ
11200		A	Removal of skin tags	0.79	1.35	1.01	0 05	010
11201		A	Remove skin tags add-on	0.29	0.20	0.15	0.02	ZZZ

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
11300		A	Shave skin lesion	0.51	1.23	0.27	0.03	000
11301		A	Shave skin lesion	0.85	1 50	0.48	0.05	000
11302		A	Shave skin lesion	1.05	1 74	0 60	0 06	000
11303		A	Shave skin lesion	1.24	2 04	0.70	0.08	000
11305		A	Shave skin lesion	0.67	1 13	0.22	0 04	000
11306		A	Shave skin lesion	0.99	1 46	0 43	0 06	000
11307		A	Shave skin lesion	1.14	1 73	0 57	0.07	000
11308		A	Shave skin lesion	1.41	1 79	0.56	0 08	000
11310		A	Shave skin lesion	0.73	1.40	0.40	0 05	000
11311		A	Shave skin lesion	1.05	1.64	0 60	0.07	000
11312		A	Shave skin lesion	1.20	1 90	0 70	0 08	000
11313		A	Shave skin lesion	1.62	2.24	0.92	0 11	000
11400		A	Exc tr-ext b9+marg 0.5 < cm	0.87	2.11	1.10	0 07	010
11401		A	Exc tr-ext b9+marg 0.6-1 cm	1.25	2.38	1.33	0.10	010
11402		A	Exc tr-ext b9+marg 1.1-2 cm	1.42	2.61	1.41	0 13	010
11403		A	Exc tr-ext b9+marg 2.1-3 cm	1.81	2.87	1.84	0.18	010
11404		A	Exc tr-ext b9+marg 3.1-4 cm	2.08	3.25	1.96	0 22	010
11406		A	Exc tr-ext b9+marg > 4.0 cm	3.47	4.16	2.60	0.45	010
11420		A	Exc h-f-nk-sp b9+marg 0.5 <	1.00	2.02	1.05	0.07	010
11421		A	Exc h-f-nk-sp b9+marg 0.6-1	1.44	2.42	1.33	0.12	010
11422		A	Exc h-f-nk-sp b9+marg 1.1-2	1.65	2.65	1.73	0.15	010
11423		A	Exc h-f-nk-sp b9+marg 2.1-3	2.03	2.96	1.91	0.20	010
11424		A	Exc h-f-nk-sp b9+marg 3.1-4	2.45	3.31	2.06	0.26	010
11426		A	Exc h-f-nk-sp b9+marg > 4 cm	4.04	4.16	2.80	0.47	010
11440		A	Exc face-mm b9+marg 0.5 < cm	1.02	2.24	1.52	0.07	010
11441		A	Exc face-mm b9+marg 0.6-1 cm	1.50	2.61	1.77	0.13	010
11442		A	Exc face-mm b9+marg 1.1-2 cm	1.74	2.88	1.89	0.16	010
11443		A	Exc face-mm b9+marg 2.1-3 cm	2.31	3 22	2.16	0.22	010
11444		A	Exc face-mm b9+marg 3.1-4 cm	3.16	3.81	2.57	0.30	010
11446		A	Exc face-mm b9+marg > 4 cm	4.75	4.91	3.43	0.47	010
11450		A	Removal, sweat gland lesion	3.14	6 05	3.00	0.47	090
11451		A	Removal, sweat gland lesion	4.35	7 37	3.58	0.66	090
11462		A	Removal, sweat gland lesion	2.92	6.16	3.01	0.43	090
11463		A	Removal, sweat gland lesion	4.35	7.59	3.66	0 64	090
11470		A	Removal, sweat gland lesion	3.66	6.40	3.27	0 53	090
11471		A	Removal, sweat gland lesion	4.81	7 59	3.79	0.68	090
1150F		I	Doc pt rsk death w/in 1yr	0.00	0.00	0.00	0 00	XXX
1151F		I	Doc no pt rsk death w/in 1yr	0.00	0.00	0.00	0.00	XXX
1152F		I	Doc advncd dis comfort 1st	0.00	0.00	0.00	0 00	XXX
1153F		I	Doc advncd dis cmfrt not 1st	0.00	0.00	0 00	0.00	XXX
1157F		I	Advnc care plan in rcrd	0.00	0 00	0 00	0 00	XXX
1158F		I	Advnc care plan tlk docd	0.00	0.00	0.00	0 00	XXX

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1159F		I	Med list docd in rcrd	0.00	0.00	0.00	0.00	XXX
11600		A	Exc tr-ext mlg+marg 0.5 < cm	1.58	3.07	1 38	0 12	010
11601		A	Exc tr-ext mlg+marg 0.6-1 cm	2.02	3.59	1 73	0.15	010
11602		A	Exc tr-ext mlg+marg 1 1-2 cm	2.22	3.88	1 91	0.16	010
11603		A	Exc tr-ext mlg+marg 2.1-3 cm	2.77	4 22	2 17	0.22	010
11604		A	Exc tr-ext mlg+marg 3.1-4 cm	3 12	4 63	2 30	0.28	010
11606		A	Exc tr-ext mlg+marg > 4 cm	4.97	6.17	3 10	0.56	010
1160F		I	Rvw meds by rx/dr in rcrd	0.00	0.00	0 00	0 00	XXX
11620		A	Exc h-f-nk-sp mlg+marg 0.5 <	1.59	3.13	1.42	0 12	010
11621		A	Exc h-f-nk-sp mlg+marg 0.6-1	2.03	3.62	1 76	0.15	010
11622		A	Exc h-f-nk-sp mlg+marg 1.1-2	2.36	3.96	1 98	0.17	010
11623		A	Exc h-f-nk-sp mlg+marg 2.1-3	3.06	4.39	2.32	0.26	010
11624		A	Exc h-f-nk-sp mlg+marg 3.1-4	3.57	4.83	2 53	0.34	010
11626		A	Exc h-f-nk-sp mlg+mar > 4 cm	4.56	5.59	2.92	0.50	010
11640		A	Exc face-mm malig+marg 0.5 <	1.62	3.26	1.50	0.13	010
11641		A	Exc face-mm malig+marg 0.6-1	2.12	3 74	1.83	0.16	010
11642		A	Exc face-mm malig+marg 1.1-2	2.57	4.15	2 11	0 20	010
11643		A	Exc face-mm malig+marg 2.1-3	3.37	4.59	2.51	0.30	010
11644		A	Exc face-mm malig+marg 3.1-4	4.29	5.54	2 99	0.41	010
11646		A	Exc face-mm mlg+marg > 4 cm	6.21	6.72	3 95	0.63	010
11719		R	Trim nail(s)	0.17	0.40	0.04	0.01	000
11720		A	Debride nail, 1-5	0.32	0.49	0.08	0.02	000
11721		A	Debride nail, 6 or more	0.54	0.57	0 13	0.03	000
11730		A	Removal of nail plate	1.10	1.41	0.27	0.06	000
11732		A	Remove nail plate, add-on	0.57	0.57	0 14	0.03	ZZZ
11740		A	Drain blood from under nail	0.37	0.86	0.46	0.02	000
11750		A	Removal of nail bed	2.40	3.16	1.99	0.14	010
11752		A	Remove nail bed/finger tip	3.48	4.47	3.04	0.28	010
11755		A	Biopsy, nail unit	1.31	2.14	0 80	0.07	000
11760		A	Repair of nail bed	1.60	4 06	1 73	0.17	010
11762		A	Reconstruction of nail bed	2.91	4.19	1.89	0.22	010
11765		A	Excision of nail fold, toe	0 71	2.88	1 07	0.04	010
11770		A	Removal of pilonidal lesion	2.63	4.11	1 92	0 37	010
11771		A	Removal of pilonidal lesion	5 98	8.03	4.69	0.92	090
11772		A	Removal of pilonidal lesion	7.23	9 66	6.87	1.09	090
1180F		I	Thromboemb risk assessed	0.00	0.00	0 00	0.00	XXX
11900		A	Injection into skin lesions	0.52	0.89	0.31	0.03	000
11901		A	Added skin lesions injection	0.80	1.00	0 48	0.04	000
11920		R	Correct skin color defects	1.61	2.68	1 34	0.22	000
11921		R	Correct skin color defects	1.93	3.06	1 54	0 28	000
11922		R	Correct skin color defects	0.49	1.05	0 28	0.07	ZZZ
11950		R	Therapy for contour defects	0.84	1.06	0.55	0 05	000

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CPT[1,7]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
11951		R	Therapy for contour defects	1.19	1.48	0.75	0.18	000
11952		R	Therapy for contour defects	1 69	1.45	0.67	0.10	000
11954		R	Therapy for contour defects	1.85	2.22	1.15	0.28	000
11960		A	Insert tissue expander(s)	11.01	NA	11.64	1.31	090
11970		A	Replace tissue expander	7 86	NA	7.48	1.17	090
11971		A	Remove tissue expander(s)	3.21	8.23	4.62	0.47	090
11975		N	Insert contraceptive cap	1.48	1.83	0.54	0.08	XXX
11976		R	Removal of contraceptive cap	1 78	1.81	0.68	0.12	000
11977		N	Removal/reinsert contra cap	3.30	2.52	1.20	0.18	XXX
11980		A	Implant hormone pellet(s)	1 48	1.17	0.62	0.10	000
11981		A	Insert drug implant device	1 48	1.80	0.58	0.18	XXX
11982		A	Remove drug implant device	1 78	1.82	0.67	0.18	XXX
11983		A	Remove/insert drug implant	3.30	2.14	1.12	0.26	XXX
12001		A	Repair superficial wound(s)	1.72	2.18	0.97	0.16	010
12002		A	Repair superficial wound(s)	1.88	2.25	1.09	0.18	010
12004		A	Repair superficial wound(s)	2.26	2.58	1.20	0.22	010
12005		A	Repair superficial wound(s)	2 88	3.12	1.37	0.29	010
12006		A	Repair superficial wound(s)	3.68	3.71	1.66	0.38	010
12007		A	Repair superficial wound(s)	4 13	4.07	1.85	0.45	010
12011		A	Repair superficial wound(s)	1.78	2.34	0.97	0.17	010
12013		A	Repair superficial wound(s)	2.01	2.53	1.12	0.19	010
12014		A	Repair superficial wound(s)	2.48	2.81	1.23	0.24	010
12015		A	Repair superficial wound(s)	3.21	3.39	1.41	0.31	010
12016		A	Repair superficial wound(s)	3 94	3 89	1.62	0.38	010
12017		A	Repair superficial wound(s)	4 72	NA	1.53	0.49	010
12018		A	Repair superficial wound(s)	5 54	NA	1.66	0.34	010
12020		A	Closure of split wound	2 64	4.21	2.09	0.27	010
12021		A	Closure of split wound	1.86	2.13	1.56	0.21	010
12031		A	Intmd wnd repair s/tr/ext	2.17	4.02	2.00	0.19	010
12032		A	Intmd wnd repair s/tr/ext	2.49	5.10	2.45	0.19	010
12034		A	Intmd wnd repair s/tr/ext	2 94	4.80	2.26	0.29	010
12035		A	Intmd wnd repair s/tr/ext	3.44	5.93	2.52	0.41	010
12036		A	Intmd wnd repair s/tr/ext	4.06	6.16	2.70	0.55	010
12037		A	Intmd wnd repair s/tr/ext	4.68	6.76	3.18	0.64	010
12041		A	Intmd wnd repair n-hf/genit	2 39	4 09	2.04	0.20	010
12042		A	Intmd wnd repair n-hg/genit	2.76	4.50	2.35	0.20	010
12044		A	Intmd wnd repair n-hg/genit	3.16	5.73	2.25	0.30	010
12045		A	Intmd wnd repair n-hg/genit	3 65	5.73	2.51	0.40	010
12046		A	Intmd wnd repair n-hg/genit	4.26	8.14	3.53	0.64	010
12047		A	Intmd wnd repair n-hg/genit	4.66	8.41	4.04	0.70	010
12051		A	Intmd wnd repair face/mm	2.49	4.23	2.16	0.21	010
12052		A	Intmd wnd repair face/mm	2.81	4.84	2.75	0.21	010
12053		A	Intmd wnd repair face/mm	3.14	5.45	2.38	0.26	010
12054		A	Intmd wnd repair, face/mm	3.47	5.71	2 33	0.32	010
12055		A	Intmd wnd repair face/mm	4.44	6.55	2.58	0.44	010
12056		A	Intmd wnd repair face/mm	5.25	7.98	2 08	0.79	010
12057		A	Intmd wnd repair face/mm	5.97	8.02	3.41	0.53	010
13100		A	Repair of wound or lesion	3.14	4.63	2.79	0.27	010
13101		A	Repair of wound or lesion	3.93	5 95	3.31	0.30	010
13102		A	Repair wound/lesion add-on	1.24	1 48	0.68	0 14	ZZZ
13120		A	Repair of wound or lesion	3.32	4.75	2.90	0.27	010
13121		A	Repair of wound or lesion	4.36	6 66	3.95	0.31	010
13122		A	Repair wound/lesion add-on	1.44	1.54	0.76	0.15	ZZZ
13131		A	Repair of wound or lesion	3.80	5.13	3.20	0.28	010
13132		A	Repair of wound or lesion	6.48	8.00	5 44	0.43	010
13133		A	Repair wound/lesion add-on	2.19	2.07	1.24	0.19	ZZZ
13150		A	Repair of wound or lesion	3.82	5.08	3.16	0.33	010
13151		A	Repair of wound or lesion	4.46	5.69	3.63	0.33	010
13152		A	Repair of wound or lesion	6.34	7.74	4.53	0.45	010
13153		A	Repair wound/lesion add-on	2.38	2.30	1.31	0.23	ZZZ
13160		A	Late closure of wound	11.84	NA	8.34	1.64	090
14000		A	Skin tissue rearrangement	6.19	9.19	6 40	0.82	090
14001		A	Skin tissue rearrangement	8.58	11.29	7.93	1.13	090
14020		A	Skin tissue rearrangement	7.02	10.24	7.27	0 88	090
14021		A	Skin tissue rearrangement	9.52	12.21	8.73	1.15	090
14040		A	Skin tissue rearrangement	8.44	10.73	7.76	0.97	090
14041		A	Skin tissue rearrangement	10.63	13.06	9.29	1.20	090
14060		A	Skin tissue rearrangement	9.07	10.46	8.13	1.02	090
14061		A	Skin tissue rearrangement	11.25	14.16	10.00	1.27	090
14300		A	Skin tissue rearrangement	13.26	14.78	10.91	1.69	090
14350		A	Skin tissue rearrangement	10.82	NA	7.74	1.13	090
15002		A	Wound prep, trk/arm/leg	3.65	4.95	2.16	0.47	000
15003		A	Wound prep, addl 100 cm	0.80	1 07	0.37	0.12	ZZZ
15004		A	Wound prep, f/n/hf/g	4.58	5.55	2 50	0.45	000
15005		A	Wnd prep, f/n/hf/g, addl cm	1.60	1.51	0.74	0.23	ZZZ
15040		A	Harvest cultured skin graft	2.00	4.43	1 33	0.24	000
15050		A	Skin punch graft	5.37	8.66	5.81	0.66	090
15100		A	Skin split grft, trnk/arm/leg	9.74	11.53	8.19	1.46	090
15101		A	Skin split grft t/a/l, add-on	1.72	2.86	1.08	0.26	ZZZ
15110		A	Epidrm autogrft trnk/arm/leg	10.88	10.49	7.86	1.63	090
15111		A	Epidrm autogrft t/a/l add-on	1.85	1.07	0.79	0.29	ZZZ
15115		A	Epidrm a-grft face/nck/hf/g	11.19	10.42	7 89	1.32	090
15116		A	Epidrm a-grft f/n/hf/g addl	2.50	1.85	1.48	0.37	ZZZ
15120		A	Skn split a-grft fac/nck/hf/g	10.96	13.00	8.98	1.42	090

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
15121		A	Skn splt a-grft f/n/hf/g add	2.67	3.98	1.67	0.38	ZZZ
15130		A	Derm autograft, trnk/arm/leg	7.41	9.20	6.61	1.10	090
15131		A	Derm autograft t/a/l add-on	1.50	0.76	0.56	0.24	ZZZ
15135		A	Derm autograft face/nck/hf/g	10.91	10.94	8.41	1.28	090
15136		A	Derm autograft, f/n/hf/g add	1.50	0.73	0 60	0.09	ZZZ
15150		A	Cult epıderm grft t/arm/leg	9.30	7 74	6.29	1 51	090
15151		A	Cult epıderm grft t/a/l addl	2.00	0.97	0.74	0 32	ZZZ
15152		A	Cult epıderm graft t/a/l +%	2.50	1 17	0.93	0.37	ZZZ
15155		A	Cult epıderm graft, f/n/hf/g	10.05	5 79	4.62	0.55	090
15156		A	Cult epıdrm grft f/n/hfg add	2 75	1.43	1.23	0 41	ZZZ
15157		A	Cult epıderm grft f/n/hfg +%	3 00	1.35	1.09	0.16	ZZZ
15170		A	Acell graft trunk/arms/legs	5 99	5.12	3.53	0.82	090
15171		A	Acell graft t/arm/leg add-on	1.55	0.81	0.66	0.24	ZZZ
15175		A	Acellular graft, f/n/hf/g	7.99	5.27	3.80	0.77	090
15176		A	Acell graft, f/n/hf/g add-on	2.45	1.28	1.01	0.30	ZZZ
15200		A	Skın full graft, trunk	8.97	11.57	7.87	1.21	090
15201		A	Skın full graft trunk add-on	1.32	2.36	0.64	0.19	ZZZ
15220		A	Skın full graft sclp/arm/leg	7.95	11.25	7.62	1.02	090
15221		A	Skın full graft add-on	1.19	2.23	0.67	0.16	ZZZ
15240		A	Skın full grft face/genıt/hf	10.15	13.08	10.07	1.25	090
15241		A	Skın full graft add-on	1.86	2.81	1.05	0.23	ZZZ
15260		A	Skın full graft een & lıps	11.39	13 85	10.48	1.24	090
15261		A	Skın full graft add-on	2.23	3.23	1.45	0.22	ZZZ
15300		A	Apply sknallogrft, t/arm/lg	4.65	4.29	2.81	0.64	090
15301		A	Apply sknallogrft t/a/l addl	1.00	0 61	0.46	0.15	ZZZ
15320		A	Apply skin allogrft f/n/hf/g	5.36	4 30	2.71	0.54	090
15321		A	Aply sknallogrft f/n/hfg add	1.50	0.87	0.68	0.23	ZZZ
15330		A	Aply acell alogrft t/arm/leg	3.99	4.26	2.75	0.59	090
15331		A	Aply acell grft t/a/l add-on	1 00	0.61	0.47	0.15	ZZZ
15335		A	Apply acell graft, f/n/hf/g	4.50	3.66	2.25	0.36	090
15336		A	Aply acell grft f/n/hf/g add	1.43	0.55	0.35	0.08	ZZZ
15340		A	Apply cult skın substıtute	3.76	4.24	3.05	0 35	010
15341		A	Apply cult skın sub add-on	0.50	0.73	0.17	0.05	ZZZ
15360		A	Apply cult derm sub, t/a/l	3.93	5.08	3.71	0.42	090
15361		A	Aply cult derm sub t/a/l add	1 15	0.65	0.45	0.15	ZZZ
15365		A	Apply cult derm sub f/n/hf/g	4.21	4.46	3.25	0.29	090
15366		A	Apply cult derm f/hf/g add	1 45	0 63	0 43	0.11	ZZZ
15400		A	Apply skın xenograft, t/a/l	4 38	6.01	4.64	0.51	090
15401		A	Apply skn xenogrft t/a/l add	1.00	1.16	0.42	0.15	ZZZ
15420		A	Apply skın xgraft, f/n/hf/g	4 89	6.22	4.92	0.49	090
15421		A	Apply skn xgrft f/n/hf/g add	1.50	1.42	0.67	0.22	ZZZ
15430		A	Apply acellular xenograft	5.93	7.59	6.97	0.71	090

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
15431		C	Apply acellular xgraft add	0.00	0.00	0.00	0 00	ZZZ
15570		A	Form skın pedıcle flap	10.00	12.12	8.01	1.53	090
15572		A	Form skın pedıcle flap	9.94	11.85	8.65	1 35	090
15574		A	Form skın pedıcle flap	10 52	12.29	8.89	1.20	090
15576		A	Form skın pedıcle flap	9.24	11.04	7.92	1.02	090
15600		A	Skın graft	1.95	5.92	3.16	0 28	090
15610		A	Skın graft	2.46	6.23	3.54	0.35	090
15620		A	Skın graft	3.62	7.09	4.45	0.45	090
15630		A	Skın graft	3.95	7 38	4.73	0.48	090
15650		A	Transfer skın pedıcle flap	4.64	7.70	4.88	0.56	090
15731		A	Forehead flap w/vasc pedıcle	14.12	14.54	11.81	1.77	090
15732		A	Muscle-skın graft, head/neck	19.70	18.32	14.55	2.15	090
15734		A	Muscle-skın graft, trunk	19.62	18.52	14.33	2.98	090
15736		A	Muscle-skın graft, arm	16.92	16.40	12.28	2.52	090
15738		A	Muscle-skın graft, leg	18.92	16.58	12 72	2.86	090
15740		A	Island pedıcle flap graft	11.57	14.05	10.37	1.29	090
15750		A	Neurovascular pedıcle graft	12.73	NA	10.43	1.70	090
15756		A	Free myo/skın flap mıcrovasc	36.74	NA	23.73	4.72	090
15757		A	Free skın flap, mıcrovasc	36.95	NA	22 86	4.33	090
15758		A	Free fascıal flap, mıcrovasc	36.70	NA	22.27	4.15	090
15760		A	Composite skın graft	9.68	11.73	8 38	1.10	090
15770		A	Derma-fat-fascıa graft	8.73	NA	7 99	1.11	090
15775		R	Haır transplant punch grafts	3.95	3.57	1.79	0.21	000
15776		R	Haır transplant punch grafts	5.53	4.89	2.37	0.30	000
15780		A	Abrasıon treatment of skın	8.50	11.86	7.11	0.89	090
15781		A	Abrasıon treatment of skın	4.91	8.60	5.84	0.57	090
15782		A	Abrasıon treatment of skın	4.36	9.13	5.35	0.47	090
15783		A	Abrasıon treatment of skın	4.33	7.73	5.16	0.46	090
15786		A	Abrasıon, lesıon, sıngle	2.05	4.17	1.52	0 18	010
15787		A	Abrasıon, lesıons, add-on	0.33	0.92	0.16	0 02	ZZZ
15788		R	Chemıcal peel, face, epıderm	2.09	9.46	4.27	0.27	090
15789		R	Chemıcal peel, face, dermal	4.91	8.73	5.67	0.53	090
15792		R	Chemıcal peel, nonfacıal	1.86	9.00	4.75	0.23	090
15793		A	Chemıcal peel, nonfacıal	3.82	8.15	5.21	0 41	090
15819		A	Plastıc surgery, neck	10.45	NA	7.89	1.56	090
15820		A	Revısıon of lower eyelıd	6.09	8.03	6.76	0 32	090
15821		A	Revısıon of lower eyelıd	6.66	8.55	7.10	0.49	090
15822		A	Revısıon of upper eyelıd	4.51	6.57	5.31	0.31	090
15823		A	Revısıon of upper eyelıd	8.12	9.70	8.29	0.49	090
15824		R	Removal of forehead wrınkles	0.00	0.00	0.00	0.00	000
15825		R	Removal of neck wrınkles	0.00	0.00	0.00	0.00	000
15826		R	Removal of brow wrınkles	0.00	0.00	0.00	0.00	000

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CPT[1,2]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
15828		R	Removal of face wrinkles	0.00	0.00	0.00	0.00	000
15829		R	Removal of skin wrinkles	0.00	0.00	0.00	0.00	000
15830		R	Exc skin abd	16.90	NA	12.60	2.48	090
15832		A	Excise excessive skin tissue	12.65	NA	9.94	1.88	090
15833		A	Excise excessive skin tissue	11.70	NA	10.42	1.75	090
15834		A	Excise excessive skin tissue	11.97	NA	10.59	1.79	090
15835		A	Excise excessive skin tissue	12.79	NA	8.25	2.07	090
15836		A	Excise excessive skin tissue	10.41	NA	7.30	1.56	090
15837		A	Excise excessive skin tissue	9.37	10.30	6.84	1.52	090
15838		A	Excise excessive skin tissue	8.07	NA	6.62	0.79	090
15839		A	Excise excessive skin tissue	10.32	11.51	8.07	1.44	090
15840		A	Graft for face nerve palsy	14.76	NA	11.42	1.68	090
15841		A	Graft for face nerve palsy	25.69	NA	16.17	2.51	090
15842		A	Flap for face nerve palsy	40.68	NA	28.59	3.97	090
15845		A	Skin and muscle repair, face	14.04	NA	11.90	0.89	090
15847		C	Exc skin abd add-on	0.00	0.00	0.00	0.00	YYY
15850		B	Removal of sutures	0.78	1.38	0.28	0.04	XXX
15851		A	Removal of sutures	0.86	1.56	0.34	0.06	000
15852		A	Dressing change not for burn	0.86	NA	0.33	0.09	000
15860		A	Test for blood flow in graft	1.95	NA	1.16	0.29	000
15876		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	000
15877		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	000
15878		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	000
15879		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	000
15920		A	Removal of tail bone ulcer	8.15	NA	6.85	1.29	090
15922		A	Removal of tail bone ulcer	10.23	NA	9.61	1.53	090
15931		A	Remove sacrum pressure sore	9.96	NA	6.95	1.58	090
15933		A	Remove sacrum pressure sore	11.60	NA	9.44	1.81	090
15934		A	Remove sacrum pressure sore	13.54	NA	9.69	2.09	090
15935		A	Remove sacrum pressure sore	15.58	NA	12.17	2.37	090
15936		A	Remove sacrum pressure sore	13.04	NA	9.32	2.00	090
15937		A	Remove sacrum pressure sore	15.00	NA	11.10	2.28	090
15940		A	Remove hip pressure sore	10.11	NA	7.25	1.56	090
15941		A	Remove hip pressure sore	12.24	NA	10.51	1.86	090
15944		A	Remove hip pressure sore	12.27	NA	10.06	1.88	090
15945		A	Remove hip pressure sore	13.57	NA	11.28	2.05	090
15946		A	Remove hip pressure sore	23.80	NA	17.42	3.60	090
15950		A	Remove thigh pressure sore	7.91	NA	6.42	1.22	090
15951		A	Remove thigh pressure sore	11.41	NA	8.41	1.71	090
15952		A	Remove thigh pressure sore	12.14	NA	8.19	1.97	090
15953		A	Remove thigh pressure sore	13.39	NA	11.92	2.00	090
15956		A	Remove thigh pressure sore	16.59	NA	12.10	2.54	090
15958		A	Remove thigh pressure sore	16.55	NA	12.84	2.53	090
15999		C	Removal of pressure sore	0.00	0.00	0.00	0.00	YYY
16000		A	Initial treatment of burn(s)	0.89	0.91	0.33	0.07	000
16020		A	Dress/debrid p-thick burn, s	0.80	1.35	0.71	0.07	000
16025		A	Dress/debrid p-thick burn, m	1.85	2.00	1.17	0.19	000
16030		A	Dress/debrid p-thick burn, l	2.08	2.52	1.34	0.25	000
16035		A	Incision of burn scab, multi	3.74	NA	1.36	0.46	000
16036		A	Escharotomy; addl incision	1.50	NA	0.64	0.19	ZZZ
17000		A	Destruct premalg lesion	0.62	1.36	0.77	0.04	010
17003		A	Destruct premalg les, 2-14	0.07	0.10	0.04	0.00	ZZZ
17004		A	Destroy premlg lesions 15+	1.82	2.43	1.51	0.10	010
17106		A	Destruction of skin lesions	3.61	4.22	3.27	0.38	090
17107		A	Destruction of skin lesions	4.68	5.44	3.98	0.52	090
17108		A	Destruction of skin lesions	6.37	7.16	5.05	0.81	090
17110		A	Destruct b9 lesion, 1-14	0.67	2.03	1.06	0.04	010
17111		A	Destruct lesion, 15 or more	0.94	2.29	1.21	0.05	010
17250		A	Chemical cautery, tissue	0.50	1.45	0.43	0.05	000
17260		A	Destruction of skin lesions	0.93	1.39	0.78	0.05	010
17261		A	Destruction of skin lesions	1.19	2.33	1.12	0.07	010
17262		A	Destruction of skin lesions	1.60	2.69	1.37	0.09	010
17263		A	Destruction of skin lesions	1.81	2.93	1.50	0.10	010
17264		A	Destruction of skin lesions	1.96	3.13	1.57	0.11	010
17266		A	Destruction of skin lesions	2.36	3.43	1.79	0.15	010
17270		A	Destruction of skin lesions	1.34	2.36	1.19	0.08	010
17271		A	Destruction of skin lesions	1.51	2.54	1.32	0.09	010
17272		A	Destruction of skin lesions	1.79	2.84	1.49	0.10	010
17273		A	Destruction of skin lesions	2.07	3.10	1.65	0.12	010
17274		A	Destruction of skin lesions	2.61	3.53	1.95	0.15	010
17276		A	Destruction of skin lesions	3.22	3.94	2.28	0.21	010
17280		A	Destruction of skin lesions	1.19	2.26	1.10	0.07	010
17281		A	Destruction of skin lesions	1.74	2.65	1.45	0.10	010
17282		A	Destruction of skin lesions	2.06	3.04	1.64	0.12	010
17283		A	Destruction of skin lesions	2.66	3.51	1.99	0.15	010
17284		A	Destruction of skin lesions	3.23	3.97	2.31	0.19	010
17286		A	Destruction of skin lesions	4.45	4.72	2.97	0.32	010
17311		A	Mohs, 1 stage, h/n/hf/g	6.20	10.16	3.75	0.35	000
17312		A	Mohs add stage	3.30	6.40	1.99	0.19	ZZZ
17313		A	Mohs, 1 stage, t/a/l	5.56	9.34	3.36	0.32	000
17314		A	Mohs, addl stage, t/a/l	3.06	5.93	1.85	0.17	ZZZ
17315		A	Mohs surg, addl block	0.87	1.13	0.53	0.05	ZZZ
17340		A	Cryotherapy of skin	0.76	0.54	0.48	0.05	010
17360		A	Skin peel therapy	1.44	1.82	1.11	0.08	010

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[4] Global totals for malpractice RVUs may not sum due to rounding.

CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
17380		R	Hair removal by electrolysis	0.00	0.00	0.00	0.00	000
17999		C	Skin tissue procedure	0.00	0.00	0.00	0.00	YYY
19000		A	Drainage of breast lesion	0.84	1 86	0.28	0.09	000
19001		A	Drain breast lesion add-on	0.42	0.25	0.14	0.04	ZZZ
19020		A	Incision of breast lesion	3.74	7.66	3.68	0.58	090
19030		A	Injection for breast x-ray	1.53	2.40	0.46	0.11	000
19100		A	Bx breast percut w/o image	1 27	2.40	0.47	0.19	000
19101		A	Biopsy of breast, open	3.20	5.11	2.24	0.49	010
19102		A	Bx breast percut w/image	2 00	3.19	0.62	0.17	000
19103		A	Bx breast percut w/device	3 69	9.61	1.19	0.36	000
19105		A	Cryosurg ablate fa, each	3.69	44.65	1.31	0.28	000
19110		A	Nipple exploration	4.35	7.57	4.03	0.70	090
19112		A	Excise breast duct fistula	3.72	7.52	3 90	0.60	090
19120		A	Removal of breast lesion	5.84	6.19	4 27	0.94	090
19125		A	Excision, breast lesion	6.59	6.78	4.64	1.06	090
19126		A	Excision, addl breast lesion	2.93	NA	1.09	0.47	ZZZ
19260		A	Removal of chest wall lesion	17.60	NA	12.21	2.95	090
19271		A	Revision of chest wall	21.86	NA	18 49	3.79	090
19272		A	Extensive chest wall surgery	24.82	NA	19 36	4.45	090
19290		A	Place needle wire, breast	1.27	2.62	0.39	0.10	000
19291		A	Place needle wire, breast	0.63	1.04	0.19	0.05	ZZZ
19295		A	Place breast clip, percut	0.00	2.12	NA	0.00	ZZZ
19296		A	Place po breast cath for rad	3.63	94.74	1.62	0.57	000
19297		A	Place breast cath for rad	1.72	NA	0.64	0.27	ZZZ
19298		A	Place breast rad tube/caths	6.00	21.64	2.42	0.58	000
19300		A	Removal of breast tissue	5.20	7 44	4 78	0.83	090
19301		A	Partical mastectomy	10.00	NA	6.02	1.60	090
19302		A	P-mastectomy w/ln removal	13.88	NA	8.10	2.23	090
19303		A	Mast, simple, complete	15 67	NA	9.20	2.52	090
19304		A	Mast, subq	7.81	NA	6.17	1.24	090
19305		A	Mast, radical	17.23	NA	10.55	2.77	090
19306		A	Mast, rad, urban type	17.85	NA	11.51	2.86	090
19307		A	Mast, mod rad	17.95	NA	11.38	2.89	090
19316		A	Suspension of breast	10.98	NA	8.49	1.65	090
19318		A	Reduction of large breast	15.91	NA	12.34	2.38	090
19324		A	Enlarge breast	6.65	NA	5.28	1.08	090
19325		A	Enlarge breast with implant	8.52	NA	7.81	1.26	090
19328		A	Removal of breast implant	6.35	NA	6.08	0.95	090
19330		A	Removal of implant material	8.39	NA	7.52	1.25	090
19340		A	Immediate breast prosthesis	6.32	NA	3.70	0.94	ZZZ
19342		A	Delayed breast prosthesis	12.40	NA	10 99	1.83	090
19350		A	Breast reconstruction	8.99	11.62	8.06	1.33	090
19355		A	Correct inverted nipple(s)	8.37	8.75	5.57	1 36	090
19357		A	Breast reconstruction	20.57	NA	18 82	3.04	090
19361		A	Breast reconstr w/lat flap	23.17	NA	20.51	3.46	090
19364		A	Breast reconstruction	42.40	NA	28 54	6.19	090
19366		A	Breast reconstruction	21.70	NA	13.02	3.38	090
19367		A	Breast reconstruction	26.59	NA	19.10	3.94	090
19368		A	Breast reconstruction	33.61	NA	23.17	5 03	090
19369		A	Breast reconstruction	31.02	NA	21.63	4 64	090
19370		A	Surgery of breast capsule	8.99	NA	8.30	1 33	090
19371		A	Removal of breast capsule	10.42	NA	9.39	1.54	090
19380		A	Revise breast reconstruction	10.21	NA	9.27	1.52	090
19396		A	Design custom breast implant	2.17	4.72	1.13	0.35	000
19499		C	Breast surgery procedure	0.00	0.00	0.00	0.00	YYY
20000		A	Incision of abscess	2.14	3.03	1.69	0.17	010
20005		A	Incision of deep abscess	3.55	4.18	2 36	0.41	010
20100		A	Explore wound, neck	10.33	NA	4.78	1.37	010
20101		A	Explore wound, chest	3.22	6.58	1.70	0.52	010
20102		A	Explore wound, abdomen	3.95	8.03	2.37	0.59	010
20103		A	Explore wound, extremity	5.31	9 14	3.48	0.71	010
20150		A	Excise epiphyseal bar	14.60	NA	8.33	2 19	090
20200		A	Muscle biopsy	1.46	3.49	0.86	0 24	000
20205		A	Deep muscle biopsy	2.35	4.57	1.43	0.37	000
20206		A	Needle biopsy, muscle	0.99	3.61	0.53	0.08	000
20220		A	Bone biopsy, trocar/needle	1.27	2.50	0 62	0.09	000
20225		A	Bone biopsy, trocar/needle	1.87	8.33	0 96	0.18	000
20240		A	Bone biopsy, excisional	3.25	NA	2.33	0.33	010
20245		A	Bone biopsy, excisional	8.77	NA	6.78	1.17	010
20250		A	Open bone biopsy	5.16	NA	4.12	0 91	010
20251		A	Open bone biopsy	5.69	NA	4.49	1 02	010
20500		A	Injection of sinus tract	1.25	1.36	0.90	0 09	010
20501		A	Inject sinus tract for x-ray	0.76	2.16	0.23	0 06	000
2050F		I	Wound char size etc docd	0.00	0.00	0.00	0.00	XXX
20520		A	Removal of foreign body	1.87	3.11	1.78	0.19	010
20525		A	Removal of foreign body	3.51	8.29	2.71	0.47	010
20526		A	Ther injection, carp tunnel	0.94	0.95	0.52	0.10	000
20550		A	Inj tendon sheath/ligament	0.75	0 72	0.33	0.06	000
20551		A	Inj tendon origin/insertion	0.75	0.79	0.38	0.06	000
20552		A	Inj trigger point, 1/2 muscl	0.66	0.72	0.33	0 05	000
20553		A	Inject trigger points, =/> 3	0.75	0.85	0.37	0.04	000
20555		A	Place ndl musc/tis for rt	6.00	NA	2.57	0 48	000
20600		A	Drain/inject, joint/bursa	0.66	0 73	0.35	0.05	000
20605		A	Drain/inject, joint/bursa	0.68	0.83	0.38	0 06	000

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
20610		A	Drain/inject, joint/bursa	0.79	1.22	0.49	0.09	000
20612		A	Aspirate/inj ganglion cyst	0.70	0.82	0.39	0.07	000
20615		A	Treatment of bone cyst	2.30	3.06	1.67	0.19	010
20650		A	Insert and remove bone pin	2.25	2.76	1.61	0.21	010
20660		A	Apply, rem fixation device	4 00	NA	1.85	0.81	000
20661		A	Application of head brace	5.14	NA	6.62	1.22	090
20662		A	Application of pelvis brace	6 26	NA	3.98	0 45	090
20663		A	Application of thigh brace	5.62	NA	5.82	0.84	090
20664		A	Halo brace application	9.86	NA	8.81	2.68	090
20665		A	Removal of fixation device	1 33	1.33	0.99	0.09	010
20670		A	Removal of support implant	1 76	7.58	1.94	0.21	010
20680		A	Removal of support implant	5.90	9.47	4.80	0.78	090
20690		A	Apply bone fixation device	8.65	NA	6.00	1.21	090
20692		A	Apply bone fixation device	16.00	NA	11.92	2.08	090
20693		A	Adjust bone fixation device	5.97	NA	5.36	0.80	090
20694		A	Remove bone fixation device	4.20	6.25	4.19	0.58	090
20696		A	Comp multiplane ext fixation	17.32	NA	10 03	0.93	090
20697		A	Comp ext fixate strut change	0.00	39.58	NA	0.00	000
20802		A	Replantation, arm, complete	42.30	NA	19.21	2.27	090
20805		A	Replant forearm, complete	51.14	NA	30.91	7.65	090
20808		A	Replantation hand, complete	62.77	NA	42.53	9.40	090
20816		A	Replantation digit, complete	31.74	NA	19.84	2.99	090
20822		A	Replantation digit, complete	26.42	NA	17.72	3.95	090
20824		A	Replantation thumb, complete	31.74	NA	19.93	4.75	090
20827		A	Replantation thumb, complete	27.24	NA	18.12	4.08	090
20838		A	Replantation foot, complete	42.56	NA	21.27	2.21	090
20900		A	Removal of bone for graft	3.00	7.32	2.50	0.42	000
20902		A	Removal of bone for graft	4.58	NA	3.16	0.67	000
20910		A	Remove cartilage for graft	5.41	NA	5.12	0.53	090
20912		A	Remove cartilage for graft	6.42	NA	5.88	0.73	090
20920		A	Removal of fascia for graft	5.42	NA	4.78	0.39	090
20922		A	Removal of fascia for graft	6.84	7.90	5.41	0.91	090
20924		A	Removal of tendon for graft	6.59	NA	5.98	0.89	090
20926		A	Removal of tissue for graft	5.70	NA	5.21	0.86	090
20930		B	Sp bone algrft morsel add-on	0.00	0.00	0.00	0.00	XXX
20931		A	Sp bone algrft struct add-on	1 81	NA	0.85	0.42	ZZZ
20936		B	Sp bone agrft local add-on	0.00	0.00	0.00	0.00	XXX
20937		A	Sp bone agrft morsel add-on	2.79	NA	1.36	0.51	ZZZ
20938		A	Sp bone agrft struct add-on	3 02	NA	1.45	0.61	ZZZ
20950		A	Fluid pressure, muscle	1.26	4.72	1.02	0.16	000
20955		A	Fibula bone graft, microvasc	40.02	NA	23.48	4.39	090
20956		A	Iliac bone graft, microvasc	40.93	NA	25.30	6.13	090
20957		A	Mt bone graft, microvasc	42.33	NA	26.49	6.34	090
20962		A	Other bone graft, microvasc	39.21	NA	27.64	5.87	090
20969		A	Bone/skin graft, microvasc	45.11	NA	26.77	4.79	090
20970		A	Bone/skin graft, iliac crest	44.26	NA	27.31	6.63	090
20972		A	Bone/skin graft, metatarsal	44.19	NA	14.56	2.40	090
20973		A	Bone/skin graft, great toe	46.95	NA	20.75	2.51	090
20974		A	Electrical bone stimulation	0.62	1.22	0.61	0.10	000
20975		A	Electrical bone stimulation	2.60	NA	1.76	0.43	000
20979		A	Us bone stimulation	0.62	0.72	0 23	0.06	000
20982		A	Ablate, bone tumor(s) perq	7.27	77.70	2 49	0.57	000
20985		A	Cptr-asst dir ms px	2.50	NA	1 23	0.37	ZZZ
20999		C	Musculoskeletal surgery	0.00	0.00	0.00	0.00	YYY
21010		A	Incision of jaw joint	10.90	NA	8.94	0.30	090
21015		A	Resection of facial tumor	5.59	NA	5.23	0.79	090
21025		A	Excision of bone, lower jaw	7.23	10.13	7.05	0.44	090
21026		A	Excision of facial bone(s)	5.54	9.10	6.41	0.39	090
21029		A	Contour of face bone lesion	8.26	10.96	7.85	0.96	090
21030		A	Excise max/zygoma b9 tumor	4.80	7.57	5.28	0.21	090
21031		A	Remove exostosis, mandible	3.26	6.03	3.83	0.09	090
21032		A	Remove exostosis, maxilla	3.28	6.21	3.79	0.11	090
21034		A	Excise max/zygoma mlg tumor	17.17	16.08	12.35	1.62	090
21040		A	Excise mandible lesion	4.80	7.53	5.22	0.17	090
21044		A	Removal of jaw bone lesion	12.61	NA	9.62	1.17	090
21045		A	Extensive jaw surgery	18.13	NA	12.73	1.59	090
21046		A	Remove mandible cyst complex	13.97	NA	12.26	0.47	090
21047		A	Excise lwr jaw cyst w/repair	19.83	NA	9.44	0.54	090
21048		A	Remove maxilla cyst complex	14.47	NA	13.55	0.54	090
21049		A	Excis uppr jaw cyst w/repair	19.08	NA	12.72	1.86	090
21050		A	Removal of jaw joint	11.54	NA	10.10	1.73	090
21060		A	Remove jaw joint cartilage	10.91	NA	10.01	0.30	090
21070		A	Remove coronoid process	8.50	NA	5.50	0.83	090
21073		A	Mnpj of tmj w/anesth	3.33	5.99	3.11	0.09	090
21076		A	Prepare face/oral prosthesis	13.40	11.42	8.32	0.38	010
21077		A	Prepare face/oral prosthesis	33.70	27.90	21.69	0.92	090
21079		A	Prepare face/oral prosthesis	22.31	19.47	14.02	0.67	090
21080		A	Prepare face/oral prosthesis	25.06	21.95	15.36	0.75	090
21081		A	Prepare face/oral prosthesis	22.85	19.98	13.92	0.67	090
21082		A	Prepare face/oral prosthesis	20.84	20.59	14.42	0.57	090
21083		A	Prepare face/oral prosthesis	19.27	20.08	13.46	0.53	090
21084		A	Prepare face/oral prosthesis	22.48	22.68	15.41	0.61	090
21085		A	Prepare face/oral prosthesis	8.99	8.87	5.70	0.27	010
21086		A	Prepare face/oral prosthesis	24.88	19.82	15.66	0.69	090

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CPT[1,3] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
21087		A	Prepare face/oral prosthesis	24.88	19.37	15.21	0.75	090
21088		C	Prepare face/oral prosthesis	0.00	0.00	0.00	0.00	090
21089		C	Prepare face/oral prosthesis	0.00	0.00	0.00	0.00	YYY
21100		A	Maxillofacial fixation	4.56	13.17	5.03	0.48	090
21110		A	Interdental fixation	5.80	13.91	10.81	0.19	090
21116		A	Injection, jaw joint,x-ray	0.81	3.15	0.38	0.05	000
21120		A	Reconstruction of chin	4.99	11.42	8.14	0.75	090
21121		A	Reconstruction of chin	7.70	9.26	6.72	0.21	090
21122		A	Reconstruction of chin	8.59	NA	7.93	0.46	090
21123		A	Reconstruction of chin	11.22	NA	11.87	0.31	090
21125		A	Augmentation, lower jaw bone	10.68	77.93	10.07	1.60	090
21127		A	Augmentation, lower jaw bone	12.24	84.54	8.92	1.19	090
21137		A	Reduction of forehead	10.12	NA	9.11	0.54	090
21138		A	Reduction of forehead	12.73	NA	10.42	1.36	090
21139		A	Reduction of forehead	14.90	NA	9.28	0.80	090
21141		A	Reconstruct midface, lefort	19.27	NA	10.00	0.53	090
21142		A	Reconstruct midface, lefort	19.98	NA	16.27	2.99	090
21143		A	Reconstruct midface, lefort	20.75	NA	13.64	3.36	090
21145		A	Reconstruct midface, lefort	23.64	NA	11.03	0.65	090
21146		A	Reconstruct midface, lefort	24.54	NA	19.69	3.67	090
21147		A	Reconstruct midface, lefort	26.14	NA	12.14	0.71	090
21150		A	Reconstruct midface, lefort	25.78	NA	14.78	1.38	090
21151		A	Reconstruct midface, lefort	28.84	NA	19.84	2.81	090
21154		A	Reconstruct midface, lefort	31.05	NA	21.25	3.03	090
21155		A	Reconstruct midface, lefort	34.98	NA	16.69	0.96	090
21159		A	Reconstruct midface, lefort	42.90	NA	26.82	4.18	090
21160		A	Reconstruct midface, lefort	46.95	NA	22.80	2.51	090
21172		A	Reconstruct orbit/forehead	28.07	NA	20.24	1.46	090
21175		A	Reconstruct orbit/forehead	33.43	NA	21.91	9.09	090
21179		A	Reconstruct entire forehead	22.53	NA	13.50	3.37	090
21180		A	Reconstruct entire forehead	25.46	NA	14.95	2.48	090
21181		A	Contour cranial bone lesion	10.18	NA	7.19	0.99	090
21182		A	Reconstruct cranial bone	32.45	NA	18.20	3.16	090
21183		A	Reconstruct cranial bone	35.57	NA	24.08	1.85	090
21184		A	Reconstruct cranial bone	38.49	NA	23.33	5.76	090
21188		A	Reconstruction of midface	22.97	NA	21.89	2.24	090
21193		A	Reconst lwr jaw w/o graft	18.65	NA	10.20	0.51	090
21194		A	Reconst lwr jaw w/graft	21.54	NA	14.12	2.10	090
21195		A	Reconst lwr jaw w/o fixation	18.88	NA	15.74	1.84	090
21196		A	Reconst lwr jaw w/fixation	20.55	NA	15.77	1.63	090
21198		A	Reconstr lwr jaw segment	15.48	NA	13.56	1.48	090
21199		A	Reconstr lwr jaw w/advance	16.62	NA	9.89	1.62	090
21206		A	Reconstruct upper jaw bone	15.36	NA	16.28	2.30	090
21208		A	Augmentation of facial bones	11.15	27.01	6.85	0.30	090
21209		A	Reduction of facial bones	7.58	15.21	9.78	0.21	090
21210		A	Face bone graft	11.40	43.37	10.09	0.44	090
21215		A	Lower jaw bone graft	11.94	80.18	9.75	0.40	090
21230		A	Rib cartilage graft	11.06	NA	9.26	1.66	090
21235		A	Ear cartilage graft	7.31	11.00	7.15	0.79	090
21240		A	Reconstruction of jaw joint	15.77	NA	10.54	0.56	090
21242		A	Reconstruction of jaw joint	14.32	NA	7.87	1.40	090
21243		A	Reconstruction of jaw joint	24.03	NA	20.16	0.66	090
21244		A	Reconstruction of lower jaw	13.35	NA	12.95	1.14	090
21245		A	Reconstruction of jaw	12.88	15.57	10.06	1.26	090
21246		A	Reconstruction of jaw	12.78	NA	8.69	1.25	090
21247		A	Reconstruct lower jaw bone	24.05	NA	15.87	3.60	090
21248		A	Reconstruction of jaw	12.54	14.42	9.77	0.44	090
21249		A	Reconstruction of jaw	18.57	14.02	9.03	0.51	090
21255		A	Reconstruct lower jaw bone	18.14	NA	16.07	1.77	090
21256		A	Reconstruction of orbit	17.42	NA	13.94	0.91	090
21260		A	Revise eye sockets	17.74	NA	12.24	0.95	090
21261		A	Revise eye sockets	33.78	NA	23.56	5.06	090
21263		A	Revise eye sockets	30.72	NA	18.73	1.65	090
21267		A	Revise eye sockets	20.45	NA	20.48	1.06	090
21268		A	Revise eye sockets	26.78	NA	28.31	1.43	090
21270		A	Augmentation, cheek bone	10.52	14.32	8.66	1.13	090
21275		A	Revision, orbitofacial bones	11.65	NA	9.83	1.74	090
21280		A	Revision of eyelid	6.92	NA	7.43	0.45	090
21282		A	Revision of eyelid	4.11	NA	5.35	0.33	090
21295		A	Revision of jaw muscle/bone	1.82	NA	2.61	0.27	090
21296		A	Revision of jaw muscle/bone	4.67	NA	4.64	0.46	090
21299		C	Cranio/maxillofacial surgery	0.00	0.00	0.00	0.00	YYY
21310		A	Treatment of nose fracture	0.58	2.40	0.14	0.06	000
21315		A	Treatment of nose fracture	1.78	5.02	1.97	0.15	010
21320		A	Treatment of nose fracture	1.86	4.57	1.61	0.14	010
21325		A	Treatment of nose fracture	4.07	NA	7.72	0.47	090
21330		A	Treatment of nose fracture	5.68	NA	8.49	0.55	090
21335		A	Treatment of nose fracture	8.91	NA	9.77	0.91	090
21336		A	Treat nasal septal fracture	6.56	NA	9.63	0.67	090
21337		A	Treat nasal septal fracture	3.26	6.69	4.06	0.36	090
21338		A	Treat nasoethmoid fracture	6.76	NA	12.07	1.01	090
21339		A	Treat nasoethmoid fracture	8.39	NA	13.04	1.26	090
21340		A	Treatment of nose fracture	11.33	NA	8.18	1.10	090
21343		A	Treatment of sinus fracture	14.11	NA	16.71	1.38	090

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
21344		A	Treatment of sinus fracture	21.36	NA	18.35	3.20	090
21345		A	Treat nose/jaw fracture	8.87	11 17	7.37	0.87	090
21346		A	Treat nose/jaw fracture	11.29	NA	12.14	1.10	090
21347		A	Treat nose/jaw fracture	13.37	NA	12.93	1.30	090
21348		A	Treat nose/jaw fracture	17.36	NA	11.14	1.69	090
21355		A	Treat cheek bone fracture	4.32	6 60	3.91	0.28	010
21356		A	Treat cheek bone fracture	4.70	7.47	4.62	0.34	010
21360		A	Treat cheek bone fracture	7.03	NA	6.28	0.69	090
21365		A	Treat cheek bone fracture	16.52	NA	11 43	1.66	090
21366		A	Treat cheek bone fracture	18 44	NA	14 38	1.80	090
21385		A	Treat eye socket fracture	9.46	NA	8.29	0.92	090
21386		A	Treat eye socket fracture	9 46	NA	6.85	1.42	090
21387		A	Treat eye socket fracture	10.00	NA	8.54	0.98	090
21390		A	Treat eye socket fracture	11.07	NA	9.14	1.02	090
21395		A	Treat eye socket fracture	14.62	NA	9.25	1.43	090
21400		A	Treat eye socket fracture	1.44	3.13	2.29	0.17	090
21401		A	Treat eye socket fracture	3.57	7.94	3.75	0.53	090
21406		A	Treat eye socket fracture	7.31	NA	6.01	0.71	090
21407		A	Treat eye socket fracture	8.91	NA	7.62	0.92	090
21408		A	Treat eye socket fracture	12.67	NA	10.46	1.90	090
21421		A	Treat mouth roof fracture	5.80	12.80	9.96	0.87	090
21422		A	Treat mouth roof fracture	8.62	NA	8.17	0.74	090
21423		A	Treat mouth roof fracture	10.71	NA	8.87	0.96	090
21431		A	Treat craniofacial fracture	7.74	NA	12.14	1.16	090
21432		A	Treat craniofacial fracture	8.76	NA	7.91	0.85	090
21433		A	Treat craniofacial fracture	26.13	NA	15.20	3.91	090
21435		A	Treat craniofacial fracture	20.02	NA	13.02	1.95	090
21436		A	Treat craniofacial fracture	30 01	NA	22.61	1.61	090
21440		A	Treat dental ridge fracture	3.28	10.24	7.85	0.09	090
21445		A	Treat dental ridge fracture	6.04	13.03	9.57	0.17	090
21450		A	Treat lower jaw fracture	3.55	10 56	8.07	0.10	090
21451		A	Treat lower jaw fracture	5.46	13.42	10.46	0.15	090
21452		A	Treat lower jaw fracture	2.29	11.34	6.03	0.34	090
21453		A	Treat lower jaw fracture	6.40	14.95	12.01	0.40	090
21454		A	Treat lower jaw fracture	7 17	NA	7.31	0.20	090
21461		A	Treat lower jaw fracture	9.07	41.24	13.65	0.71	090
21462		A	Treat lower jaw fracture	10.77	41.30	14.02	0.69	090
21465		A	Treat lower jaw fracture	12.88	NA	7.23	0.35	090
21470		A	Treat lower jaw fracture	17 24	NA	12.32	1.25	090
21480		A	Reset dislocated jaw	0.61	1.65	0.22	0.05	000
21485		A	Reset dislocated jaw	4 58	12.66	9.87	0.15	090
21490		A	Repair dislocated jaw	12.71	NA	7.14	0.35	090

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
21495		A	Treat hyoid bone fracture	6 55	NA	11.40	0.35	090
21497		A	Interdental wiring	4 45	12.38	9 79	0.12	090
21499		C	Head surgery procedure	0 00	0.00	0 00	0.00	YYY
21501		A	Drain neck/chest lesion	3.87	7.35	4 10	0.55	090
21502		A	Drain chest lesion	7 43	NA	5 72	1.20	090
21510		A	Drainage of bone lesion	6 06	NA	4.79	1.08	090
21550		A	Biopsy of neck/chest	2 08	4.34	1 88	0.18	010
21555		A	Remove lesion, neck/chest	4 40	6 75	4.18	0.66	090
21556		A	Remove lesion, neck/chest	5 63	NA	5 01	0.80	090
21557		A	Remove tumor, neck/chest	8.91	NA	5 79	1 27	090
21600		A	Partial removal of rib	7.14	NA	6 92	1.17	090
21610		A	Partial removal of rib	15.76	NA	11.91	4.28	090
21615		A	Removal of rib	10.31	NA	5.90	1.86	090
21616		A	Removal of rib and nerves	12.54	NA	6.26	2.26	090
21620		A	Partial removal of sternum	7.16	NA	5.63	1.22	090
21627		A	Sternal debridement	7.18	NA	6.42	1.24	090
21630		A	Extensive sternum surgery	19.01	NA	12.35	3.02	090
21632		A	Extensive sternum surgery	19.51	NA	11.13	3 71	090
21685		A	Hyoid myotomy & suspension	14.89	NA	10.70	1.44	090
21700		A	Revision of neck muscle	6.23	NA	3.21	1.12	090
21705		A	Revision of neck muscle/rib	9.83	NA	4.26	1.77	090
21720		A	Revision of neck muscle	5.72	NA	4.76	1.56	090
21725		A	Revision of neck muscle	7.10	NA	6.20	1.06	090
21740		A	Reconstruction of sternum	17.47	NA	8.21	3.32	090
21742		C	Repair stern/nuss w/o scope	0.00	0.00	0.00	0.00	090
21743		C	Repair sternum/nuss w/scope	0.00	0.00	0 00	0.00	090
21750		A	Repair of sternum separation	11.35	NA	5 91	2.05	090
21800		A	Treatment of rib fracture	0.98	1.66	1 74	0.13	090
21805		A	Treatment of rib fracture	2.80	NA	3.70	0.50	090
21810		A	Treatment of rib fracture(s)	6.92	NA	5.50	1.23	090
21820		A	Treat sternum fracture	1 31	2.12	2.20	0.18	090
21825		A	Treat sternum fracture	7.65	NA	6.39	1.37	090
21899		C	Neck/chest surgery procedure	0.00	0.00	0 00	0.00	YYY
21920		A	Biopsy soft tissue of back	2 08	4.37	2.02	0.18	010
21925		A	Biopsy soft tissue of back	4.54	6.20	4.04	0.68	090
21930		A	Remove lesion, back or flank	5.06	7.12	4.62	0.79	090
21935		A	Remove tumor, back	18.38	NA	10.94	2.84	090
22010		A	I&d, p-spine, c/t/cerv-thor	12.57	NA	10.01	2.44	090
22015		A	I&d, p-spine, l/s/ls	12.46	NA	10 04	2.28	090
22100		A	Remove part of neck vertebra	10.80	NA	9 61	2.94	090
22101		A	Remove part, thorax vertebra	10.88	NA	10 51	2.96	090
22102		A	Remove part, lumbar vertebra	10.88	NA	8.99	2.04	090

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22103		A	Remove extra spine segment	2.34	NA	1.14	0.51	ZZZ
22110		A	Remove part of neck vertebra	13.80	NA	10.81	3.75	090
22112		A	Remove part, thorax vertebra	13.87	NA	11.91	3.77	090
22114		A	Remove part, lumbar vertebra	13.87	NA	10.91	2.08	090
22116		A	Remove extra spine segment	2.32	NA	1.11	0.45	ZZZ
22206		A	Cut spine 3 col, thor	37.00	NA	22.07	5.54	090
22207		A	Cut spine 3 col, lumb	36.50	NA	21.98	6.87	090
22208		A	Cut spine 3 col, addl seg	9.66	NA	4.73	1.94	ZZZ
22210		A	Revision of neck spine	25.13	NA	17.35	5.09	090
22212		A	Revision of thorax spine	20.74	NA	15.18	3.74	090
22214		A	Revision of lumbar spine	20.77	NA	15.24	3.84	090
22216		A	Revise, extra spine segment	6.03	NA	2.95	1.14	ZZZ
22220		A	Revision of neck spine	22.69	NA	16.13	4.81	090
22222		A	Revision of thorax spine	22.84	NA	15.98	3.42	090
22224		A	Revision of lumbar spine	22.84	NA	15.71	4.02	090
22226		A	Revise, extra spine segment	6.03	NA	2.89	1.18	ZZZ
22305		A	Treat spine process fracture	2.08	2.60	2.19	0.31	090
22310		A	Treat spine fracture	3.69	3.60	3.04	0.56	090
22315		A	Treat spine fracture	9.91	11.45	8.75	1.89	090
22318		A	Treat odontoid fx w/o graft	22.54	NA	15.52	5.77	090
22319		A	Treat odontoid fx w/graft	25.15	NA	17.00	6.84	090
22325		A	Treat spine fracture	19.62	NA	14.62	4.23	090
22326		A	Treat neck spine fracture	20.64	NA	14.51	4.73	090
22327		A	Treat thorax spine fracture	20.52	NA	14.97	4.18	090
22328		A	Treat each add spine fx	4.60	NA	2.22	1.01	ZZZ
22505		A	Manipulation of spine	1.87	NA	1.16	0.15	010
22520		A	Percut vertebroplasty thor	9.17	42.28	3.90	0.82	010
22521		A	Percut vertebroplasty lumb	8.60	43.41	3.74	0.77	010
22522		A	Percut vertebroplasty addÆl	4.30	NA	1.53	0.42	ZZZ
22523		A	Percut kyphoplasty, thor	9.21	NA	5.13	1.39	010
22524		A	Percut kyphoplasty, lumbar	8.81	NA	4.97	1.32	010
22525		A	Percut kyphoplasty, add-on	4.47	NA	1.95	0.73	ZZZ
22526		N	Idet, single level	6.07	51.03	2.91	0.45	010
22527		N	Idet, 1 or more levels	3.03	43.86	1.11	0.18	ZZZ
22532		A	Lat thorax spine fusion	25.81	NA	17.01	5.75	090
22533		A	Lat lumbar spine fusion	24.61	NA	16.46	4.84	090
22534		A	Lat thor/lumb, addÆl seg	5.99	NA	2.89	1.18	ZZZ
22548		A	Neck spine fusion	26.86	NA	17.98	7.30	090
22554		A	Neck spine fusion	17.54	NA	12.63	4.11	090
22556		A	Thorax spine fusion	24.50	NA	15.66	4.98	090
22558		A	Lumbar spine fusion	23.33	NA	14.41	4.26	090
22585		A	Additional spinal fusion	5.52	NA	2.62	1.20	ZZZ
22590		A	Spine & skull spinal fusion	21.56	NA	15.49	5.30	090
22595		A	Neck spinal fusion	20.44	NA	14.91	4.93	090
22600		A	Neck spine fusion	17.20	NA	13.22	3.98	090
22610		A	Thorax spine fusion	17.08	NA	12.98	3.64	090
22612		A	Lumbar spine fusion	23.38	NA	15.27	4.69	090
22614		A	Spine fusion, extra segment	6.43	NA	3.10	1.31	ZZZ
22630		A	Lumbar spine fusion	21.89	NA	15.12	4.72	090
22632		A	Spine fusion, extra segment	5.22	NA	2.52	1.11	ZZZ
22800		A	Fusion of spine	19.30	NA	13.64	3.68	090
22802		A	Fusion of spine	31.91	NA	19.74	5.66	090
22804		A	Fusion of spine	37.30	NA	22.24	6.37	090
22808		A	Fusion of spine	27.31	NA	16.96	5.47	090
22810		A	Fusion of spine	31.30	NA	18.55	5.99	090
22812		A	Fusion of spine	34.00	NA	21.32	5.09	090
22818		A	Kyphectomy, 1-2 segments	34.18	NA	20.35	5.12	090
22819		A	Kyphectomy, 3 or more	39.18	NA	24.22	10.65	090
22830		A	Exploration of spinal fusion	11.13	NA	8.52	2.16	090
22840		A	Insert spine fixation device	12.52	NA	6.05	2.58	ZZZ
22841		B	Insert spine fixation device	0.00	0.00	0.00	0.00	XXX
22842		A	Insert spine fixation device	12.56	NA	6.07	2.56	ZZZ
22843		A	Insert spine fixation device	13.44	NA	6.50	2.62	ZZZ
22844		A	Insert spine fixation device	16.42	NA	8.04	2.76	ZZZ
22845		A	Insert spine fixation device	11.94	NA	5.71	2.70	ZZZ
22846		A	Insert spine fixation device	12.40	NA	5.93	2.80	ZZZ
22847		A	Insert spine fixation device	13.78	NA	6.47	3.75	ZZZ
22848		A	Insert pelv fixation device	5.99	NA	2.94	1.05	ZZZ
22849		A	Reinsert spinal fixation	19.08	NA	12.48	3.88	090
22850		A	Remove spine fixation device	9.74	NA	7.68	1.96	090
22851		A	Apply spine prosth device	6.70	NA	3.22	1.42	ZZZ
22852		A	Remove spine fixation device	9.29	NA	7.43	1.82	090
22855		A	Remove spine fixation device	15.77	NA	10.96	3.59	090
22856		A	Cerv artific diskectomy	23.90	NA	15.34	1.28	090
22857		R	Lumbar artif diskectomy	26.93	NA	13.82	7.32	090
22861		A	Revise cerv artific disc	33.21	NA	14.50	1.78	090
22862		R	Revise lumbar artif disc	32.43	NA	15.86	4.85	090
22864		A	Remove cerv artif disc	29.25	NA	13.06	1.57	090
22865		R	Remove lumb artif disc	31.55	NA	19.75	4.72	090
22899		C	Spine surgery procedure	0.00	0.00	0.00	0.00	YYY
22900		A	Remove abdominal wall lesion	6.14	NA	4.48	0.96	090
22999		C	Abdomen surgery procedure	0.00	0.00	0.00	0.00	YYY
23000		A	Removal of calcium deposits	4.40	9.57	4.62	0.64	090
23020		A	Release shoulder joint	9.24	NA	7.86	1.34	090

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
23030		A	Drain shoulder lesion	3.44	7.25	2.86	0.50	010
23031		A	Drain shoulder bursa	2.76	7.06	2.51	0.35	010
23035		A	Drain shoulder bone lesion	9.04	NA	7.76	1.35	090
23040		A	Exploratory shoulder surgery	9.63	NA	8.15	1.43	090
23044		A	Exploratory shoulder surgery	7.48	NA	6.70	1.12	090
23065		A	Biopsy shoulder tissues	2.28	3.15	1.96	0.22	010
23066		A	Biopsy shoulder tissues	4 21	9.06	4.39	0.63	090
23075		A	Removal of shoulder lesion	2.41	4.35	2.13	0.37	010
23076		A	Removal of shoulder lesion	7.77	NA	6.52	1 20	090
23077		A	Remove tumor of shoulder	18.08	NA	12.11	2.79	090
23100		A	Biopsy of shoulder joint	6.09	NA	6.14	0 91	090
23101		A	Shoulder joint surgery	5.63	NA	5.38	0.84	090
23105		A	Remove shoulder joint lining	8.36	NA	7.32	1.25	090
23106		A	Incision of collarbone joint	6.02	NA	6.11	0.90	090
23107		A	Explore treat shoulder joint	8.75	NA	7 55	1.30	090
23120		A	Partial removal, collar bone	7.23	NA	7.12	1.07	090
23125		A	Removal of collar bone	9.52	NA	7.95	1.42	090
23130		A	Remove shoulder bone, part	7 63	NA	7.28	1.14	090
23140		A	Removal of bone lesion	7.01	NA	5.84	1.03	090
23145		A	Removal of bone lesion	9.28	NA	7.83	1.39	090
23146		A	Removal of bone lesion	7.96	NA	7.28	1.19	090
23150		A	Removal of humerus lesion	8.79	NA	7.53	1.30	090
23155		A	Removal of humerus lesion	10.72	NA	8.83	1.60	090
23156		A	Removal of humerus lesion	8.99	NA	7.69	1 35	090
23170		A	Remove collar bone lesion	7.10	NA	6.64	1.06	090
23172		A	Remove shoulder blade lesion	7.20	NA	6 69	1.08	090
23174		A	Remove humerus lesion	9.90	NA	8.74	1.48	090
23180		A	Remove collar bone lesion	8.85	NA	7 59	1.34	090
23182		A	Remove shoulder blade lesion	8.47	NA	7.82	1.27	090
23184		A	Remove humerus lesion	9.76	NA	8.40	1.44	090
23190		A	Partial removal of scapula	7.36	NA	6.67	1.10	090
23195		A	Removal of head of humerus	10.24	NA	8.40	1.53	090
23200		A	Removal of collar bone	12.69	NA	9.89	1.90	090
23210		A	Removal of shoulder blade	13.16	NA	10.12	1.97	090
23220		A	Partial removal of humerus	15.36	NA	11.42	2.30	090
23221		A	Partial removal of humerus	18.41	NA	12.92	2.76	090
23222		A	Partial removal of humerus	25.44	NA	16.48	3.81	090
23330		A	Remove shoulder foreign body	1.87	4.06	1 93	0.23	010
23331		A	Remove shoulder foreign body	7.51	NA	7.02	1.11	090
23332		A	Remove shoulder foreign body	12.23	NA	9 66	1.80	090
23350		A	Injection for shoulder x-ray	1.00	2.56	0.33	0.08	000
23395		A	Muscle transfer,shoulder/arm	18.29	NA	13.64	2.69	090
23397		A	Muscle transfers	16.62	NA	11.71	2.49	090
23400		A	Fixation of shoulder blade	13.73	NA	10.31	2 06	090
23405		A	Incision of tendon & muscle	8.43	NA	7.17	1.25	090
23406		A	Incise tendon(s) & muscle(s)	10.90	NA	8.39	1.59	090
23410		A	Repair rotator cuff, acute	11.23	NA	9 10	1.67	090
23412		A	Repair rotator cuff, chronic	11.77	NA	9.37	1 75	090
23415		A	Release of shoulder ligament	10.64	NA	8.75	1 35	090
23420		A	Repair of shoulder	13.35	NA	10.64	1.99	090
23430		A	Repair biceps tendon	10.05	NA	8.22	1.49	090
23440		A	Remove/transplant tendon	10.53	NA	8.25	1 55	090
23450		A	Repair shoulder capsule	13.58	NA	9.96	2.03	090
23455		A	Repair shoulder capsule	14.55	NA	10.43	2.16	090
23460		A	Repair shoulder capsule	15.68	NA	11 36	2.35	090
23462		A	Repair shoulder capsule	15.60	NA	11 04	2.34	090
23465		A	Repair shoulder capsule	16.16	NA	11 54	2.42	090
23466		A	Repair shoulder capsule	15.55	NA	12 25	2.31	090
23470		A	Reconstruct shoulder joint	17.75	NA	12.40	2.64	090
23472		A	Reconstruct shoulder joint	22.47	NA	14.91	3.32	090
23480		A	Revision of collar bone	11.42	NA	8.89	1 71	090
23485		A	Revision of collar bone	13.79	NA	10.05	2 03	090
23490		A	Reinforce clavicle	12.04	NA	9.30	1 80	090
23491		A	Reinforce shoulder bones	14.40	NA	10 77	2.16	090
23500		A	Treat clavicle fracture	2.13	3.13	3.21	0.30	090
23505		A	Treat clavicle fracture	3.74	4.80	4.34	0.54	090
23515		A	Treat clavicle fracture	9.53	NA	8.46	1.42	090
23520		A	Treat clavicle dislocation	2.21	3.34	3.42	0.33	090
23525		A	Treat clavicle dislocation	3 67	5.58	4 90	0.55	090
23530		A	Treat clavicle dislocation	7.37	NA	6.68	1.10	090
23532		A	Treat clavicle dislocation	8.08	NA	7.24	1.21	090
23540		A	Treat clavicle dislocation	2.28	3.11	3.19	0.32	090
23545		A	Treat clavicle dislocation	3.32	4.60	3.90	0.44	090
23550		A	Treat clavicle dislocation	7.48	NA	6.60	1.10	090
23552		A	Treat clavicle dislocation	8 70	NA	7 57	1.29	090
23570		A	Treat shoulder blade fx	2.28	3.31	3.47	0.33	090
23575		A	Treat shoulder blade fx	4.12	5.56	4 96	0 62	090
23585		A	Treat scapula fracture	14.07	NA	10.42	2 07	090
23600		A	Treat humerus fracture	3.00	4.81	4.33	0.44	090
23605		A	Treat humerus fracture	4 94	6.36	5 45	0.72	090
23615		A	Treat humerus fracture	12.12	NA	9.79	1 80	090
23616		A	Treat humerus fracture	18.19	NA	12.81	2.70	090
23620		A	Treat humerus fracture	2.46	4.03	3.73	0.36	090
23625		A	Treat humerus fracture	3.99	5.25	4.65	0 59	090

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23630		A	Treat humerus fracture	10.39	NA	8.93	1.55	090
23650		A	Treat shoulder dislocation	3.44	3.93	3.37	0.44	090
23655		A	Treat shoulder dislocation	4.64	NA	4.99	0.66	090
23660		A	Treat shoulder dislocation	7.55	NA	6.87	1.12	090
23665		A	Treat dislocation/fracture	4.54	5.79	5.12	0.66	090
23670		A	Treat dislocation/fracture	12.12	NA	9.65	1.81	090
23675		A	Treat dislocation/fracture	6.13	7.16	6.01	0.88	090
23680		A	Treat dislocation/fracture	12.99	NA	10.05	1.94	090
23700		A	Fixation of shoulder	2.54	NA	2.28	0.36	010
23800		A	Fusion of shoulder joint	14.59	NA	10.83	2.18	090
23802		A	Fusion of shoulder joint	18.17	NA	13.56	2.72	090
23900		A	Amputation of arm & girdle	20.57	NA	13.98	3.08	090
23920		A	Amputation at shoulder joint	16.03	NA	11.85	2.40	090
23921		A	Amputation follow-up surgery	5.61	NA	4.84	1.01	090
23929		C	Shoulder surgery procedure	0.00	0.00	0.00	0.00	YYY
23930		A	Drainage of arm lesion	2.96	5.78	2.41	0.44	010
23931		A	Drainage of arm bursa	1.81	5.07	2.10	0.24	010
23935		A	Drain arm/elbow bone lesion	6.27	NA	5.99	0.92	090
24000		A	Exploratory elbow surgery	5.99	NA	5.75	0.87	090
24006		A	Release elbow joint	9.62	NA	8.00	1.35	090
24065		A	Biopsy arm/elbow soft tissue	2.10	4.25	2.12	0.20	010
24066		A	Biopsy arm/elbow soft tissue	5.26	9.73	4.81	0.80	090
24075		A	Remove arm/elbow lesion	3.96	8.27	3.95	0.60	090
24076		A	Remove arm/elbow lesion	6.36	NA	5.60	0.97	090
24077		A	Remove tumor of arm/elbow	11.95	NA	8.46	1.84	090
24100		A	Biopsy elbow joint lining	4.98	NA	5.22	0.75	090
24101		A	Explore/treat elbow joint	6.19	NA	6.06	0.91	090
24102		A	Remove elbow joint lining	8.15	NA	7.07	1.16	090
24105		A	Removal of elbow bursa	3.67	NA	4.81	0.54	090
24110		A	Remove humerus lesion	7.46	NA	6.94	1.12	090
24115		A	Remove/graft bone lesion	10.00	NA	6.91	1.50	090
24116		A	Remove/graft bone lesion	12.11	NA	9.23	1.81	090
24120		A	Remove elbow lesion	6.71	NA	6.24	0.97	090
24125		A	Remove/graft bone lesion	8.02	NA	7.22	1.20	090
24126		A	Remove/graft bone lesion	8.50	NA	7.45	1.27	090
24130		A	Removal of head of radius	6.31	NA	6.19	0.90	090
24134		A	Removal of arm bone lesion	10.10	NA	8.33	1.51	090
24136		A	Remove radius bone lesion	8.29	NA	7.22	1.24	090
24138		A	Remove elbow bone lesion	8.33	NA	8.15	1.25	090
24140		A	Partial removal of arm bone	9.43	NA	8.01	1.34	090
24145		A	Partial removal of radius	7.70	NA	6.84	1.15	090
24147		A	Partial removal of elbow	7.69	NA	7.53	1.12	090
24149		A	Radical resection of elbow	15.92	NA	13.13	2.21	090
24150		A	Extensive humerus surgery	13.70	NA	10.38	2.05	090
24151		A	Extensive humerus surgery	16.08	NA	11.77	2.41	090
24152		A	Extensive radius surgery	10.24	NA	8.30	1.53	090
24153		A	Extensive radius surgery	11.73	NA	6.33	0.85	090
24155		A	Removal of elbow joint	11.97	NA	9.15	1.79	090
24160		A	Remove elbow joint implant	7.89	NA	7.07	1.12	090
24164		A	Remove radius head implant	6.34	NA	5.88	0.95	090
24200		A	Removal of arm foreign body	1.78	3.24	1.68	0.20	010
24201		A	Removal of arm foreign body	4.61	9.02	4.39	0.69	090
24220		A	Injection for elbow x-ray	1.31	2.65	0.47	0.10	000
24300		A	Manipulate elbow w/anesth	3.86	NA	5.96	0.53	090
24301		A	Muscle/tendon transfer	10.26	NA	8.29	1.54	090
24305		A	Arm tendon lengthening	7.51	NA	6.85	1.02	090
24310		A	Revision of arm tendon	6.03	NA	5.75	0.89	090
24320		A	Repair of arm tendon	10.74	NA	8.55	1.61	090
24330		A	Revision of arm muscles	9.67	NA	8.02	1.45	090
24331		A	Revision of arm muscles	10.83	NA	8.59	1.62	090
24332		A	Tenolysis, triceps	7.77	NA	7.23	1.16	090
24340		A	Repair of biceps tendon	7.96	NA	7.14	1.19	090
24341		A	Repair arm tendon/muscle	9.24	NA	9.04	1.36	090
24342		A	Repair of ruptured tendon	10.74	NA	8.59	1.56	090
24343		A	Repr elbow lat ligmnt w/tiss	8.99	NA	8.51	1.25	090
24344		A	Reconstruct elbow lat ligmnt	14.97	NA	12.06	2.24	090
24345		A	Repr elbw med ligmnt w/tissu	8.99	NA	8.38	1.26	090
24346		A	Reconstruct elbow med ligmnt	14.97	NA	12.06	2.24	090
24357		A	Repair elbow, perc	5.32	NA	5.63	0.77	090
24358		A	Repair elbow w/deb, open	6.54	NA	6.34	0.93	090
24359		A	Repair elbow deb/attch open	8.86	NA	7.50	1.26	090
24360		A	Reconstruct elbow joint	12.53	NA	9.70	1.88	090
24361		A	Reconstruct elbow joint	14.27	NA	10.65	2.14	090
24362		A	Reconstruct elbow joint	15.18	NA	11.10	2.27	090
24363		A	Replace elbow joint	22.47	NA	15.10	3.17	090
24365		A	Reconstruct head of radius	8.51	NA	7.22	1.27	090
24366		A	Reconstruct head of radius	9.25	NA	7.64	1.31	090
24400		A	Revision of humerus	11.19	NA	9.16	1.64	090
24410		A	Revision of humerus	14.96	NA	11.22	2.24	090
24420		A	Revision of humerus	13.58	NA	10.91	2.03	090
24430		A	Repair of humerus	15.07	NA	11.27	2.20	090
24435		A	Repair humerus with graft	14.74	NA	11.92	2.17	090
24470		A	Revision of elbow joint	8.81	NA	7.69	1.32	090
24495		A	Decompression of forearm	8.30	NA	7.51	1.34	090

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24498		A	Reinforce humerus	12.16	NA	9.31	1.82	090
24500		A	Treat humerus fracture	3.29	5.29	4.54	0.47	090
24505		A	Treat humerus fracture	5.25	6.88	5.77	0.77	090
24515		A	Treat humerus fracture	11.97	NA	9.74	1.77	090
24516		A	Treat humerus fracture	12.07	NA	9.30	1.80	090
24530		A	Treat humerus fracture	3.57	5.61	4.76	0.52	090
24535		A	Treat humerus fracture	6.96	8.12	7.01	1.02	090
24538		A	Treat humerus fracture	9.63	NA	8.60	1.43	090
24545		A	Treat humerus fracture	12.99	NA	10.07	1.91	090
24546		A	Treat humerus fracture	14.73	NA	11.08	2.16	090
24560		A	Treat humerus fracture	2.87	4.86	4.07	0.41	090
24565		A	Treat humerus fracture	5.64	7.26	6.22	0.84	090
24566		A	Treat humerus fracture	8.86	NA	8.63	1.33	090
24575		A	Treat humerus fracture	9.53	NA	8.50	1.40	090
24576		A	Treat humerus fracture	2.94	5.24	4.43	0.43	090
24577		A	Treat humerus fracture	5.87	7.43	6.34	0.88	090
24579		A	Treat humerus fracture	11.26	NA	9.38	1.65	090
24582		A	Treat humerus fracture	9.89	NA	9.79	1.48	090
24586		A	Treat elbow fracture	15.64	NA	11.37	2.27	090
24587		A	Treat elbow fracture	15.65	NA	11.54	2.20	090
24600		A	Treat elbow dislocation	4.28	4.53	3.85	0.57	090
24605		A	Treat elbow dislocation	5.50	NA	5.88	0.81	090
24615		A	Treat elbow dislocation	9.72	NA	7.96	1.38	090
24620		A	Treat elbow fracture	7.07	NA	6.39	0.99	090
24635		A	Treat elbow fracture	8.64	NA	7.94	1.25	090
24640		A	Treat elbow dislocation	1.22	2.01	1.00	0.13	010
24650		A	Treat radius fracture	2.22	4.06	3.56	0.32	090
24655		A	Treat radius fracture	4.48	6.15	5.23	0.64	090
24665		A	Treat radius fracture	8.22	NA	7.84	1.19	090
24666		A	Treat radius fracture	9.74	NA	8.44	1.39	090
24670		A	Treat ulnar fracture	2.60	4.39	3.73	0.37	090
24675		A	Treat ulnar fracture	4.79	6.27	5.33	0.70	090
24685		A	Treat ulnar fracture	8.21	NA	7.85	1.21	090
24800		A	Fusion of elbow joint	11.27	NA	9.19	1.69	090
24802		A	Fusion/graft of elbow joint	14.18	NA	10.62	2.12	090
24900		A	Amputation of upper arm	10.04	NA	7.97	1.52	090
24920		A	Amputation of upper arm	10.02	NA	8.07	1.50	090
24925		A	Amputation follow-up surgery	7.19	NA	6.68	1.08	090
24930		A	Amputation follow-up surgery	10.72	NA	8.41	1.60	090
24931		A	Amputate upper arm & implant	13.32	NA	7.03	0.71	090
24935		A	Revision of amputation	16.30	NA	12.25	2.44	090
24940		C	Revision of upper arm	0.00	NA	0.00	0.00	090
24999		C	Upper arm/elbow surgery	0.00	0.00	0.00	0.00	YYY
25000		A	Incision of tendon sheath	3.44	NA	4.72	0.47	090
25001		A	Incise flexor carpi radialis	3.68	NA	4.69	0.50	090
25020		A	Decompress forearm 1 space	5.97	NA	8.21	0.80	090
25023		A	Decompress forearm 1 space	13.69	NA	14.11	2.05	090
25024		A	Decompress forearm 2 spaces	10.62	NA	8.48	1.57	090
25025		A	Decompress forearm 2 spaces	17.77	NA	12.65	2.66	090
25028		A	Drainage of forearm lesion	5.30	NA	7.45	0.76	090
25031		A	Drainage of forearm bursa	4.18	NA	4.70	0.63	090
25035		A	Treat forearm bone lesion	7.54	NA	6.53	1.07	090
25040		A	Explore/treat wrist joint	7.41	NA	6.52	1.02	090
25065		A	Biopsy forearm soft tissues	2.01	4.32	2.13	0.17	010
25066		A	Biopsy forearm soft tissues	4.18	NA	4.54	0.59	090
25075		A	Removal forearm lesion subcu	3.78	NA	3.96	0.56	090
25076		A	Removal forearm lesion deep	4.97	NA	4.94	0.72	090
25077		A	Remove tumor, forearm/wrist	9.90	NA	7.60	1.51	090
25085		A	Incision of wrist capsule	5.55	NA	5.49	0.83	090
25100		A	Biopsy of wrist joint	3.94	NA	4.48	0.59	090
25101		A	Explore/treat wrist joint	4.74	NA	5.19	0.67	090
25105		A	Remove wrist joint lining	5.91	NA	6.02	0.82	090
25107		A	Remove wrist joint cartilage	7.50	NA	7.64	1.01	090
25109		A	Excise tendon forearm/wrist	6.81	NA	6.48	0.92	090
25110		A	Remove wrist tendon lesion	3.96	NA	4.37	0.57	090
25111		A	Remove wrist tendon lesion	3.44	NA	4.34	0.49	090
25112		A	Reremove wrist tendon lesion	4.58	NA	4.86	0.65	090
25115		A	Remove wrist/forearm lesion	9.89	NA	8.91	1.33	090
25116		A	Remove wrist/forearm lesion	4.83	NA	6.09	0.99	090
25118		A	Excise wrist tendon sheath	4.42	NA	4.96	0.60	090
25119		A	Partial removal of ulna	6.10	NA	6.05	0.91	090
25120		A	Removal of forearm lesion	6.16	NA	6.08	0.86	090
25125		A	Remove/graft forearm lesion	7.55	NA	6.98	1.13	090
25126		A	Remove/graft forearm lesion	7.62	NA	7.02	1.14	090
25130		A	Removal of wrist lesion	5.32	NA	5.71	0.73	090
25135		A	Remove & graft wrist lesion	6.96	NA	7.06	1.04	090
25136		A	Remove & graft wrist lesion	6.03	NA	6.01	0.90	090
25145		A	Remove forearm bone lesion	6.43	NA	6.21	0.96	090
25150		A	Partial removal of ulna	7.27	NA	6.65	1.01	090
25151		A	Partial removal of radius	7.57	NA	6.93	1.13	090
25170		A	Extensive forearm surgery	11.34	NA	9.01	1.70	090
25210		A	Removal of wrist bone	6.01	NA	6.07	0.80	090
25215		A	Removal of wrist bones	8.02	NA	7.32	1.05	090
25230		A	Partial removal of radius	5.28	NA	5.40	0.67	090

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CPT[1,2]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
25240		A	Partial removal of ulna	5.22	NA	5.38	0.69	090
25246		A	Injection for wrist x-ray	1.45	2.56	0.49	0.12	000
25248		A	Remove forearm foreign body	5.20	NA	4.93	0.77	090
25250		A	Removal of wrist prosthesis	6.66	NA	6.31	1.00	090
25251		A	Removal of wrist prosthesis	9.70	NA	8.03	1.45	090
25259		A	Manipulate wrist w/anesthes	3.86	NA	6.01	0.54	090
25260		A	Repair forearm tendon/muscle	7.89	NA	7.64	1.09	090
25263		A	Repair forearm tendon/muscle	7.90	NA	7.44	1.18	090
25265		A	Repair forearm tendon/muscle	9.96	NA	8.45	1.49	090
25270		A	Repair forearm tendon/muscle	6.06	NA	6.09	0.85	090
25272		A	Repair forearm tendon/muscle	7.10	NA	6.57	0.99	090
25274		A	Repair forearm tendon/muscle	8.82	NA	7.61	1.32	090
25275		A	Repair forearm tendon sheath	8.82	NA	7.74	1.32	090
25280		A	Revise wrist/forearm tendon	7.28	NA	6.77	0.97	090
25290		A	Incise wrist/forearm tendon	5.34	NA	5.41	0.72	090
25295		A	Release wrist/forearm tendon	6.61	NA	6.34	0.88	090
25300		A	Fusion of tendons at wrist	8.88	NA	7.92	1.33	090
25301		A	Fusion of tendons at wrist	8.47	NA	7.52	1.17	090
25310		A	Transplant forearm tendon	7.94	NA	7.44	1.03	090
25312		A	Transplant forearm tendon	9.70	NA	8.21	1.32	090
25315		A	Revise palsy hand tendon(s)	10.56	NA	8.46	1.58	090
25316		A	Revise palsy hand tendon(s)	12.76	NA	10.62	1.20	090
25320		A	Repair/revise wrist joint	12.38	NA	11.93	1.66	090
25332		A	Revise wrist joint	11.60	NA	9.29	1.64	090
25335		A	Realignment of hand	13.25	NA	7.20	0.71	090
25337		A	Reconstruct ulna/radioulnar	11.44	NA	10.51	1.50	090
25350		A	Revision of radius	8.97	NA	7.77	1.21	090
25355		A	Revision of radius	10.41	NA	8.49	1.56	090
25360		A	Revision of ulna	8.62	NA	7.55	1.24	090
25365		A	Revise radius & ulna	12.77	NA	9.84	1.91	090
25370		A	Revise radius or ulna	13.93	NA	10.91	2.09	090
25375		A	Revise radius & ulna	13.41	NA	7.26	0.72	090
25390		A	Shorten radius or ulna	10.58	NA	8.66	1.41	090
25391		A	Lengthen radius or ulna	14.14	NA	10.51	2.12	090
25392		A	Shorten radius & ulna	14.44	NA	10.66	2.16	090
25393		A	Lengthen radius & ulna	16.42	NA	11.63	2.46	090
25394		A	Repair carpal bone, shorten	10.71	NA	8.60	1.60	090
25400		A	Repair radius or ulna	11.16	NA	8.90	1.56	090
25405		A	Repair/graft radius or ulna	14.87	NA	11.05	2.06	090
25415		A	Repair radius & ulna	13.66	NA	10.71	2.04	090
25420		A	Repair/graft radius & ulna	16.89	NA	12.08	2.53	090
25425		A	Repair/graft radius or ulna	13.58	NA	10.23	2.03	090

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CPT[1,2]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
25426		A	Repair/graft radius & ulna	16.31	NA	11.58	2.44	090
25430		A	Vasc graft into carpal bone	9.57	NA	8.94	0.90	090
25431		A	Repair nonunion carpal bone	10.75	NA	8.69	1.61	090
25440		A	Repair/graft wrist bone	10.56	NA	8.46	1.43	090
25441		A	Reconstruct wrist joint	13.15	NA	10.83	1.24	090
25442		A	Reconstruct wrist joint	10.98	NA	9.24	1.03	090
25443		A	Reconstruct wrist joint	10.52	NA	8.71	1.57	090
25444		A	Reconstruct wrist joint	11.28	NA	6.47	0.60	090
25445		A	Reconstruct wrist joint	9.76	NA	8.15	1.32	090
25446		A	Wrist replacement	17.16	NA	12.32	2.21	090
25447		A	Repair wrist joint(s)	10.95	NA	9.61	1.46	090
25449		A	Remove wrist joint implant	14.80	NA	10.82	2.22	090
25450		A	Revision of wrist joint	7.94	NA	6.28	1.19	090
25455		A	Revision of wrist joint	9.57	NA	5.85	0.51	090
25490		A	Reinforce radius	9.61	NA	7.14	0.94	090
25491		A	Reinforce ulna	10.03	NA	8.20	1.50	090
25492		A	Reinforce radius and ulna	12.52	NA	9.81	1.87	090
25500		A	Treat fracture of radius	2.51	4.01	3.49	0.34	090
25505		A	Treat fracture of radius	5.30	6.95	5.97	0.76	090
25515		A	Treat fracture of radius	8.64	NA	7.83	1.25	090
25520		A	Treat fracture of radius	6.35	7.42	6.72	0.95	090
25525		A	Treat fracture of radius	10.37	NA	8.89	1.51	090
25526		A	Treat fracture of radius	12.96	NA	10.43	1.94	090
25530		A	Treat fracture of ulna	2.15	4.12	3.53	0.31	090
25535		A	Treat fracture of ulna	5.22	6.69	5.84	0.74	090
25545		A	Treat fracture of ulna	7.78	NA	7.52	1.12	090
25560		A	Treat fracture radius & ulna	2.50	4.12	3.50	0.34	090
25565		A	Treat fracture radius & ulna	5.71	7.00	5.87	0.82	090
25574		A	Treat fracture radius & ulna	8.64	NA	7.94	1.27	090
25575		A	Treat fracture radius/ulna	12.10	NA	10.12	1.76	090
25600		A	Treat fracture radius/ulna	2.69	4.37	3.78	0.38	090
25605		A	Treat fracture radius/ulna	7.02	8.14	7.29	1.02	090
25606		A	Treat fx distal radial	8.10	NA	8.03	1.19	090
25607		A	Treat fx rad extra-articul	9.35	NA	8.70	1.35	090
25608		A	Treat fx rad intra-articul	10.86	NA	9.48	1.55	090
25609		A	Treat fx radial 3+ frag	14.12	NA	11.77	2.00	090
25622		A	Treat wrist bone fracture	2.68	4.65	4.01	0.38	090
25624		A	Treat wrist bone fracture	4.62	6.63	5.65	0.66	090
25628		A	Treat wrist bone fracture	9.51	NA	8.32	1.29	090
25630		A	Treat wrist bone fracture	2.94	4.49	3.90	0.41	090
25635		A	Treat wrist bone fracture	4.47	6.49	5.55	0.67	090
25645		A	Treat wrist bone fracture	7.31	NA	6.64	1.09	090

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25650		A	Treat wrist bone fracture	3.12	4.59	4.12	0.43	090
25651		A	Pin ulnar styloid fracture	5.68	NA	6.19	0.82	090
25652		A	Treat fracture ulnar styloid	7.92	NA	7.46	1.09	090
25660		A	Treat wrist dislocation	4.84	NA	5.22	0.67	090
25670		A	Treat wrist dislocation	7.98	NA	7.04	1.12	090
25671		A	Pin radioulnar dislocation	6.32	NA	6.61	0.95	090
25675		A	Treat wrist dislocation	4.75	5.80	4.94	0.64	090
25676		A	Treat wrist dislocation	8.17	NA	7.34	1.14	090
25680		A	Treat wrist fracture	6.08	NA	5.50	0.77	090
25685		A	Treat wrist fracture	9.97	NA	8.17	1.49	090
25690		A	Treat wrist dislocation	5.58	NA	6.08	0.84	090
25695		A	Treat wrist dislocation	8.40	NA	7.18	1.26	090
25800		A	Fusion of wrist joint	9.95	NA	8.33	1.35	090
25805		A	Fusion/graft of wrist joint	11.59	NA	9.25	1.73	090
25810		A	Fusion/graft of wrist joint	11.75	NA	9.80	1.57	090
25820		A	Fusion of hand bones	7.52	NA	7.72	1.02	090
25825		A	Fuse hand bones with graft	9.54	NA	9.24	1.27	090
25830		A	Fusion, radioulnar int/ulna	10.69	NA	12.66	1.60	090
25900		A	Amputation of forearm	9.46	NA	8.04	1.37	090
25905		A	Amputation of forearm	9.48	NA	7.81	1.42	090
25907		A	Amputation follow-up surgery	7.98	NA	7.07	1.19	090
25909		A	Amputation follow-up surgery	9.20	NA	7.67	1.38	090
25915		A	Amputation of forearm	17.38	NA	6.61	2.32	090
25920		A	Amputate hand at wrist	8.92	NA	8.21	1.34	090
25922		A	Amputate hand at wrist	7.54	NA	5.23	0.40	090
25924		A	Amputation follow-up surgery	8.70	NA	8.47	1.30	090
25927		A	Amputation of hand	8.98	NA	10.85	1.34	090
25929		A	Amputation follow-up surgery	7.71	NA	6.93	1.15	090
25931		A	Amputation follow-up surgery	7.93	NA	10.31	1.19	090
25999		C	Forearm or wrist surgery	0.00	0.00	0.00	0.00	YYY
26010		A	Drainage of finger abscess	1.56	4.78	1.85	0.17	010
26011		A	Drainage of finger abscess	2.21	7.25	2.39	0.29	010
26020		A	Drain hand tendon sheath	4.97	NA	5.70	0.69	090
26025		A	Drainage of palm bursa	4.99	NA	5.47	0.69	090
26030		A	Drainage of palm bursa(s)	6.16	NA	6.06	0.86	090
26034		A	Treat hand bone lesion	6.49	NA	6.72	0.90	090
26035		A	Decompress fingers/hand	11.14	NA	9.84	1.67	090
26037		A	Decompress fingers/hand	7.48	NA	6.70	1.08	090
26040		A	Release palm contracture	3.38	NA	4.30	0.43	090
26045		A	Release palm contracture	5.62	NA	5.85	0.82	090
26055		A	Incise finger tendon sheath	3.00	10.44	4.52	0.41	090
26060		A	Incision of finger tendon	2.85	NA	3.68	0.40	090
26070		A	Explore/treat hand joint	3.73	NA	3.83	0.46	090
26075		A	Explore/treat finger joint	3.83	NA	4.16	0.49	090
26080		A	Explore/treat finger joint	4.36	NA	5.16	0.59	090
26100		A	Biopsy hand joint lining	3.71	NA	4.42	0.56	090
26105		A	Biopsy finger joint lining	3.75	NA	4.44	0.56	090
26110		A	Biopsy finger joint lining	3.57	NA	4.33	0.47	090
26115		A	Removal hand lesion subcut	3.92	11.24	4.99	0.54	090
26116		A	Removal hand lesion, deep	5.61	NA	6.36	0.75	090
26117		A	Remove tumor, hand/finger	8.62	NA	7.50	1.19	090
26121		A	Release palm contracture	7.61	NA	7.19	1.05	090
26123		A	Release palm contracture	10.63	NA	9.96	1.43	ZZZ
26125		A	Release palm contracture	4.60	NA	2.43	0.62	090
26130		A	Remove wrist joint lining	5.48	NA	5.83	0.82	090
26135		A	Revise finger joint, each	7.02	NA	6.59	0.95	090
26140		A	Revise finger joint, each	6.23	NA	6.22	0.84	090
26145		A	Tendon excision, palm/finger	6.38	NA	6.26	0.87	090
26160		A	Remove tendon sheath lesion	3.46	10.40	4.67	0.48	090
26170		A	Remove/graft bone lesion, each	4.82	NA	5.23	0.64	090
26180		A	Removal of finger tendon	5.24	NA	5.74	0.68	090
26185		A	Remove finger bone	6.32	NA	6.99	0.95	090
26200		A	Remove hand bone lesion	5.56	NA	5.54	0.77	090
26205		A	Remove/graft bone lesion	7.82	NA	6.96	1.17	090
26210		A	Removal of finger lesion	5.21	NA	5.67	0.71	090
26215		A	Remove/graft finger lesion	7.16	NA	6.63	1.07	090
26230		A	Partial removal of hand bone	6.38	NA	5.98	0.84	090
26235		A	Partial removal, finger bone	6.24	NA	6.03	0.82	090
26236		A	Partial removal, finger bone	5.37	NA	5.55	0.72	090
26250		A	Extensive hand surgery	7.61	NA	6.83	1.14	090
26255		A	Extensive hand surgery	12.80	NA	9.89	1.92	090
26260		A	Extensive finger surgery	7.09	NA	6.57	1.06	090
26261		A	Extensive finger surgery	9.28	NA	8.43	0.87	090
26262		A	Partial removal of finger	5.72	NA	5.62	0.86	090
26320		A	Removal of implant from hand	4.02	NA	4.53	0.53	090
26340		A	Manipulate finger w/anesth	2.62	NA	5.35	0.37	090
26350		A	Repair finger/hand tendon	6.07	NA	11.05	0.83	090
26352		A	Repair/graft hand tendon	7.75	NA	11.87	1.16	090
26356		A	Repair finger/hand tendon	10.22	NA	16.04	1.41	090
26357		A	Repair finger/hand tendon	8.65	NA	12.31	1.29	090
26358		A	Repair/graft hand tendon	9.22	NA	12.88	0.87	090
26370		A	Repair finger/hand tendon	7.17	NA	11.25	1.01	090
26372		A	Repair/graft hand tendon	8.89	NA	12.43	1.33	090
26373		A	Repair finger/hand tendon	8.29	NA	12.14	1.24	090

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CPT[1],] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
26390		A	Revise hand/finger tendon	9.31	NA	10.92	1.39	090
26392		A	Repair/graft hand tendon	10.38	NA	13.16	1.55	090
26410		A	Repair hand tendon	4.68	NA	8.93	0.66	090
26412		A	Repair/graft hand tendon	6.37	NA	10.14	0.85	090
26415		A	Excision, hand/finger tendon	8.40	NA	8.97	0.85	090
26416		A	Graft hand or finger tendon	9.44	NA	11.95	1.41	090
26418		A	Repair finger tendon	4.33	NA	9.46	0.61	090
26420		A	Repair/graft finger tendon	6.83	NA	10.45	1.02	090
26426		A	Repair finger/hand tendon	6.21	NA	6.18	0.85	090
26428		A	Repair/graft finger tendon	7.28	NA	10.89	1.09	090
26432		A	Repair finger tendon	4.07	NA	7.95	0.55	090
26433		A	Repair finger tendon	4.61	NA	8.17	0.64	090
26434		A	Repair/graft finger tendon	6.15	NA	9.36	0.92	090
26437		A	Realignment of tendons	5.88	NA	9.16	0.77	090
26440		A	Release palm/finger tendon	5.07	NA	9.90	0.67	090
26442		A	Release palm & finger tendon	9.50	NA	13.87	1.29	090
26445		A	Release hand/finger tendon	4.36	NA	9.54	0.59	090
26449		A	Release forearm/hand tendon	8.34	NA	8.78	1.12	090
26450		A	Incision of palm tendon	3.71	NA	6.13	0.52	090
26455		A	Incision of finger tendon	3.68	NA	6.05	0.51	090
26460		A	Incise hand/finger tendon	3.50	NA	5.97	0.46	090
26471		A	Fusion of finger tendons	5.79	NA	9.11	0.77	090
26474		A	Fusion of finger tendons	5.38	NA	8.98	0.81	090
26476		A	Tendon lengthening	5.24	NA	8.91	0.78	090
26477		A	Tendon shortening	5.21	NA	8.85	0.76	090
26478		A	Lengthening of hand tendon	5.86	NA	9.17	0.82	090
26479		A	Shortening of hand tendon	5.80	NA	9.19	0.87	090
26480		A	Transplant hand tendon	6.76	NA	11.32	0.90	090
26483		A	Transplant/graft hand tendon	8.36	NA	11.93	1.18	090
26485		A	Transplant palm tendon	7.77	NA	11.78	1.05	090
26489		A	Transplant/graft palm tendon	9.74	NA	12.85	1.46	090
26490		A	Revise thumb tendon	8.48	NA	10.73	1.07	090
26492		A	Tendon transfer with graft	9.70	NA	11.61	1.45	090
26494		A	Hand tendon/muscle transfer	8.54	NA	10.76	1.28	090
26496		A	Revise thumb tendon	9.66	NA	11.43	1.25	090
26497		A	Finger tendon transfer	9.64	NA	11.30	1.44	090
26498		A	Finger tendon transfer	14.07	NA	13.76	2.11	090
26499		A	Revision of finger	9.05	NA	11.01	1.35	090
26500		A	Hand tendon reconstruction	6.02	NA	9.14	0.85	090
26502		A	Hand tendon reconstruction	7.20	NA	9.88	1.08	090
26508		A	Release thumb contracture	6.07	NA	9.02	0.91	090
26510		A	Thumb tendon transfer	5.49	NA	8.94	0.70	090

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CPT[1],] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
26516		A	Fusion of knuckle joint	7.21	NA	9.84	0.96	090
26517		A	Fusion of knuckle joints	8.96	NA	10.96	1.34	090
26518		A	Fusion of knuckle joints	9.15	NA	11.06	1.37	090
26520		A	Release knuckle contracture	5.36	NA	10.34	0.73	090
26525		A	Release finger contracture	5.39	NA	10.34	0.71	090
26530		A	Revise knuckle joint	6.76	NA	6.51	0.92	090
26531		A	Revise knuckle with implant	7.99	NA	7.50	1.04	090
26535		A	Revise finger joint	5.30	NA	5.05	0.61	090
26536		A	Revise/implant finger joint	6.44	NA	10.86	0.83	090
26540		A	Repair hand joint	6.49	NA	9.47	0.88	090
26541		A	Repair hand joint with graft	8.69	NA	10.92	1.12	090
26542		A	Repair hand joint with graft	6.84	NA	9.46	0.94	090
26545		A	Reconstruct finger joint	6.99	NA	9.94	0.94	090
26546		A	Repair nonunion hand	10.53	NA	13.30	1.38	090
26548		A	Reconstruct finger joint	8.10	NA	10.40	1.10	090
26550		A	Construct thumb replacement	21.54	NA	18.80	3.22	090
26551		A	Great toe-hand transfer	48.23	NA	33.56	7.22	090
26553		A	Single transfer, toe-hand	47.92	NA	23.97	2.57	090
26554		A	Double transfer, toe-hand	56.73	NA	27.52	3.04	090
26555		A	Positional change of finger	16.94	NA	17.43	2.54	090
26556		A	Toe joint transfer	49.43	NA	13.79	6.60	090
26560		A	Repair of web finger	5.43	NA	8.57	0.81	090
26561		A	Repair of web finger	10.98	NA	9.99	1.78	090
26562		A	Repair of web finger	16.40	NA	11.37	0.88	090
26565		A	Correct metacarpal flaw	6.80	NA	9.65	1.02	090
26567		A	Correct finger deformity	6.88	NA	9.69	0.92	090
26568		A	Lengthen metacarpal/finger	9.15	NA	12.56	1.37	090
26580		A	Repair hand deformity	19.50	NA	17.40	2.92	090
26587		A	Reconstruct extra finger	14.36	NA	9.17	2.33	090
26590		A	Repair finger deformity	18.51	NA	15.96	2.77	090
26591		A	Repair muscles of hand	3.30	NA	7.03	0.45	090
26593		A	Release muscles of hand	5.38	NA	9.17	0.69	090
26596		A	Excision constricting tissue	9.02	NA	9.49	1.35	090
26600		A	Treat metacarpal fracture	2.48	4.57	4.16	0.35	090
26605		A	Treat metacarpal fracture	2.92	4.84	4.17	0.41	090
26607		A	Treat metacarpal fracture	5.40	NA	5.77	0.78	090
26608		A	Treat metacarpal fracture	5.43	NA	6.26	0.77	090
26615		A	Treat metacarpal fracture	6.91	NA	7.22	0.96	090
26641		A	Treat thumb dislocation	4.01	4.98	4.22	0.53	090
26645		A	Treat thumb fracture	4.47	5.87	5.04	0.67	090
26650		A	Treat thumb fracture	5.19	NA	6.45	0.74	090
26665		A	Treat thumb fracture	7.78	NA	7.70	1.09	090

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CPT[1,5] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
26670		A	Treat hand dislocation	3.74	4.40	3.69	0.49	090
26675		A	Treat hand dislocation	4.71	6.27	5.41	0.70	090
26676		A	Pin hand dislocation	5.60	NA	6.64	0.78	090
26685		A	Treat hand dislocation	6.91	NA	7.21	1.03	090
26686		A	Treat hand dislocation	8.06	NA	7.25	1.21	090
26700		A	Treat knuckle dislocation	3.74	4.05	3.60	0.48	090
26705		A	Treat knuckle dislocation	4.26	5.85	5.00	0.61	090
26706		A	Pin knuckle dislocation	5.19	NA	5.63	0.71	090
26715		A	Treat knuckle dislocation	6.87	NA	7.13	0.97	090
26720		A	Treat finger fracture, each	1.70	3.07	2.75	0.23	090
26725		A	Treat finger fracture, each	3.39	4.85	4.08	0.47	090
26727		A	Treat finger fracture, each	5.30	NA	6.20	0.74	090
26735		A	Treat finger fracture, each	7.26	NA	7.42	1.02	090
26740		A	Treat finger fracture, each	1.99	3.54	3.21	0.26	090
26742		A	Treat finger fracture, each	3.90	5.09	4.29	0.53	090
26746		A	Treat finger fracture, each	9.59	NA	8.73	1.31	090
26750		A	Treat finger fracture, each	1.74	2.71	2.72	0.24	090
26755		A	Treat finger fracture, each	3.15	4.47	3.54	0.43	090
26756		A	Pin finger fracture, each	4.46	NA	5.75	0.62	090
26765		A	Treat finger fracture, each	5.70	NA	6.56	0.80	090
26770		A	Treat finger dislocation	3.07	3.58	3.13	0.40	090
26775		A	Treat finger dislocation	3.78	5.51	4.64	0.51	090
26776		A	Pin finger dislocation	4.87	NA	5.92	0.68	090
26785		A	Treat finger dislocation	6.44	NA	6.95	0.90	090
26820		A	Thumb fusion with graft	8.33	NA	10.65	1.25	090
26841		A	Fusion of thumb	7.21	NA	10.38	1.03	090
26842		A	Thumb fusion with graft	8.37	NA	10.67	1.25	090
26843		A	Fusion of hand joint	7.67	NA	10.11	1.15	090
26844		A	Fusion/graft of hand joint	8.86	NA	10.91	1.33	090
26850		A	Fusion of knuckle	7.03	NA	9.80	0.92	090
26852		A	Fusion of knuckle with graft	8.59	NA	10.83	1.09	090
26860		A	Fusion of finger joint	4.76	NA	8.80	0.63	090
26861		A	Fusion of finger jnt, add-on	1.74	NA	0.91	0.23	ZZZ
26862		A	Fusion/graft of finger joint	7.44	NA	10.26	0.98	090
26863		A	Fuse/graft added joint	3.89	NA	1.91	0.58	ZZZ
26910		A	Amputate metacarpal bone	7.67	NA	9.74	1.11	090
26951		A	Amputation of finger/thumb	5.85	NA	9.82	0.83	090
26952		A	Amputation of finger/thumb	6.37	NA	9.26	0.89	090
26989		C	Hand/finger surgery	0.00	0.00	0.00	0.00	YYY
26990		A	Drainage of pelvis lesion	7.84	NA	7.47	1.18	090
26991		A	Drainage of pelvis bursa	6.97	10.32	5.98	1.05	090
26992		A	Drainage of bone lesion	13.37	NA	10.45	2.02	090
27000		A	Incision of hip tendon	5.66	NA	5.06	0.79	090
27001		A	Incision of hip tendon	7.05	NA	6.30	1.05	090
27003		A	Incision of hip tendon	7.70	NA	6.93	1.15	090
27005		A	Incision of hip tendon	9.96	NA	8.05	1.49	090
27006		A	Incision of hip tendons	9.99	NA	8.21	1.47	090
27025		A	Incision of hip/thigh fascia	12.66	NA	9.84	1.91	090
27027		A	Buttock fasciotomy	12.90	NA	9.15	0.69	090
27030		A	Drainage of hip joint	13.54	NA	9.81	2.01	090
27033		A	Exploration of hip joint	13.99	NA	10.20	2.09	090
27035		A	Denervation of hip joint	17.23	NA	12.03	2.58	090
27036		A	Excision of hip joint/muscle	14.18	NA	10.77	2.09	090
27040		A	Biopsy of soft tissues	2.89	5.52	2.09	0.33	010
27041		A	Biopsy of soft tissues	10.07	NA	6.65	1.36	090
27047		A	Remove hip/pelvis lesion	7.51	8.49	5.66	1.18	090
27048		A	Remove hip/pelvis lesion	6.44	NA	5.63	1.00	090
27049		A	Remove tumor, hip/pelvis	15.20	NA	9.92	2.26	090
27050		A	Biopsy of sacroiliac joint	4.65	NA	5.15	0.75	090
27052		A	Biopsy of hip joint	7.27	NA	6.85	1.09	090
27054		A	Removal of hip joint lining	9.09	NA	7.84	1.36	090
27057		A	Buttock fasciotomy w/dbrdmt	14.77	NA	10.40	0.79	090
27060		A	Removal of ischial bursa	5.78	NA	4.64	0.87	090
27062		A	Remove femur lesion/bursa	5.66	NA	5.52	0.85	090
27065		A	Removal of hip bone lesion	6.44	NA	6.04	0.95	090
27066		A	Removal of hip bone lesion	11.06	NA	9.03	1.66	090
27067		A	Remove/graft hip bone lesion	14.57	NA	11.03	2.18	090
27070		A	Partial removal of hip bone	11.44	NA	9.76	1.71	090
27071		A	Partial removal of hip bone	12.25	NA	10.29	1.84	090
27075		A	Extensive hip surgery	36.77	NA	20.24	5.50	090
27076		A	Extensive hip surgery	24.25	NA	15.90	3.63	090
27077		A	Extensive hip surgery	42.54	NA	24.53	6.37	090
27078		A	Extensive hip surgery	14.54	NA	11.02	2.18	090
27079		A	Extensive hip surgery	14.91	NA	11.20	2.23	090
27080		A	Removal of tail bone	6.80	NA	5.81	1.06	090
27086		A	Remove hip foreign body	1.89	4.14	1.76	0.19	010
27087		A	Remove hip foreign body	8.72	NA	6.98	1.29	090
27090		A	Removal of hip prosthesis	11.57	NA	9.02	1.72	090
27091		A	Removal of hip prosthesis	24.15	NA	15.86	3.61	090
27093		A	Injection for hip x-ray	1.30	3.46	0.55	0.11	000
27095		A	Injection for hip x-ray	1.50	4.32	0.64	0.14	000
27096		A	Inject sacroiliac joint	1.40	3.49	0.55	0.09	000
27097		A	Revision of hip tendon	9.16	NA	7.65	1.37	090
27098		A	Transfer tendon to pelvis	9.20	NA	5.88	1.38	090

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CPT[1,2] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
27100		A	Transfer of abdominal muscle	11.21	NA	9.16	1.68	090
27105		A	Transfer of spinal muscle	11.90	NA	9.50	1.78	090
27110		A	Transfer of iliopsoas muscle	13.63	NA	10.35	2.04	090
27111		A	Transfer of iliopsoas muscle	12.46	NA	9.77	1.87	090
27120		A	Reconstruction of hip socket	19.10	NA	13.24	2.86	090
27122		A	Reconstruction of hip socket	15.95	NA	11.47	2.37	090
27125		A	Partial hip replacement	16.46	NA	11.72	2.46	090
27130		A	Total hip arthroplasty	21.61	NA	14.46	3.23	090
27132		A	Total hip arthroplasty	25.49	NA	16.53	3.81	090
27134		A	Revise hip joint replacement	30.13	NA	18.16	4.50	090
27137		A	Revise hip joint replacement	22.55	NA	14.44	3.37	090
27138		A	Revise hip joint replacement	23.55	NA	14.93	3.52	090
27140		A	Transplant femur ridge	12.66	NA	9.59	1.90	090
27146		A	Incision of hip bone	18.72	NA	13.17	2.80	090
27147		A	Revision of hip bone	21.87	NA	14.72	3.27	090
27151		A	Incision of hip bones	23.92	NA	15.73	3.58	090
27156		A	Revision of hip bones	26.03	NA	16.77	3.90	090
27158		A	Revision of pelvis	20.89	NA	14.04	3.13	090
27161		A	Incision of neck of femur	17.74	NA	12.51	2.64	090
27165		A	Incision/fixation of femur	20.06	NA	14.14	2.99	090
27170		A	Repair/graft femur head/neck	17.46	NA	11.93	2.61	090
27175		A	Treat slipped epiphysis	9.29	NA	7.22	1.39	090
27176		A	Treat slipped epiphysis	12.78	NA	9.93	1.91	090
27177		A	Treat slipped epiphysis	15.94	NA	11.70	2.39	090
27178		A	Treat slipped epiphysis	12.78	NA	9.93	1.91	090
27179		A	Revise head/neck of femur	13.83	NA	10.35	2.07	090
27181		A	Treat slipped epiphysis	15.98	NA	11.82	2.39	090
27185		A	Revision of femur epiphysis	9.67	NA	5.70	0.52	090
27187		A	Reinforce hip bones	14.09	NA	10.55	2.11	090
27193		A	Treat pelvic ring fracture	5.98	5.57	5.73	0.89	090
27194		A	Treat pelvic ring fracture	10.08	NA	7.14	1.21	090
27200		A	Treat tail bone fracture	1.87	2.52	2.69	0.26	090
27202		A	Treat tail bone fracture	7.25	NA	5.93	1.09	090
27215		I	Treat pelvic fracture(s)	10.45	NA	5.53	0.56	090
27216		I	Treat pelvic ring fracture	15.73	NA	8.00	0.84	090
27217		I	Treat pelvic ring fracture	14.65	NA	7.60	0.78	090
27218		I	Treat pelvic ring fracture	20.93	NA	9.89	1.12	090
27220		A	Treat hip socket fracture	6.72	6.33	6.22	1.00	090
27222		A	Treat hip socket fracture	13.97	NA	10.22	2.05	090
27226		A	Treat hip wall fracture	15.45	NA	10.95	2.31	090
27227		A	Treat hip fracture(s)	25.21	NA	16.34	3.77	090
27228		A	Treat hip fracture(s)	29.13	NA	18.27	4.36	090
27230		A	Treat thigh fracture	5.69	5.96	5.88	0.84	090
27232		A	Treat thigh fracture	11.66	NA	7.38	1.71	090
27235		A	Treat thigh fracture	12.88	NA	9.68	1.92	090
27236		A	Treat thigh fracture	17.43	NA	12.38	2.60	090
27238		A	Treat thigh fracture	5.64	NA	5.64	0.84	090
27240		A	Treat thigh fracture	13.66	NA	10.13	2.02	090
27244		A	Treat thigh fracture	18.00	NA	12.66	2.68	090
27245		A	Treat thigh fracture	18.00	NA	12.68	2.68	090
27246		A	Treat thigh fracture	4.75	4.70	4.74	0.70	090
27248		A	Treat thigh fracture	10.64	NA	7.81	1.59	090
27250		A	Treat hip dislocation	3.82	NA	0.82	0.39	000
27252		A	Treat hip dislocation	10.92	NA	7.91	1.60	090
27253		A	Treat hip dislocation	13.46	NA	9.93	2.01	090
27254		A	Treat hip dislocation	18.80	NA	12.76	2.81	090
27256		A	Treat hip dislocation	4.25	2.96	1.74	0.45	010
27257		A	Treat hip dislocation	5.35	NA	2.96	0.64	010
27258		A	Treat hip dislocation	16.04	NA	11.53	2.40	090
27259		A	Treat hip dislocation	23.03	NA	15.58	3.45	090
27265		A	Treat hip dislocation	5.12	NA	4.55	0.69	090
27266		A	Treat hip dislocation	7.67	NA	6.63	1.14	090
27267		A	Ctx thigh fx	5.38	NA	5.40	0.81	090
27268		A	Ctx thigh fx w/mnpj	7.00	NA	6.20	1.05	090
27269		A	Optx thigh fx	18.75	NA	12.33	2.78	090
27275		A	Manipulation of hip joint	2.29	NA	2.07	0.26	010
27280		A	Fusion of sacroiliac joint	14.49	NA	11.02	2.24	090
27282		A	Fusion of pubic bones	11.71	NA	9.40	1.75	090
27284		A	Fusion of hip joint	24.91	NA	15.56	3.73	090
27286		A	Fusion of hip joint	24.97	NA	16.24	3.74	090
27290		A	Amputation of leg at hip	24.38	NA	16.14	3.65	090
27295		A	Amputation of leg at hip	19.54	NA	11.90	3.04	090
27299		C	Pelvis/hip joint surgery	0.00	0.00	0.00	0.00	YYY
27301		A	Drain thigh/knee lesion	6.67	9.71	5.65	1.02	090
27303		A	Drainage of bone lesion	8.52	NA	7.29	1.27	090
27305		A	Incise thigh tendon & fascia	6.09	NA	5.67	0.92	090
27306		A	Incision of thigh tendon	4.66	NA	4.93	0.70	090
27307		A	Incision of thigh tendons	5.97	NA	5.79	0.89	090
27310		A	Exploration of knee joint	9.88	NA	8.21	1.47	090
27323		A	Biopsy, thigh soft tissues	2.30	4.45	2.17	0.27	010
27324		A	Biopsy, thigh soft tissues	4.95	NA	4.60	0.77	090
27325		A	Neurectomy, hamstring	7.09	NA	6.57	1.06	090
27326		A	Neurectomy, popliteal	6.36	NA	6.21	0.95	090
27327		A	Removal of thigh lesion	4.52	7.08	4.35	0.70	090

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CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
27328		A	Removal of thigh lesion	5.62	NA	4.95	0.87	090
27329		A	Remove tumor, thigh/knee	15.68	NA	10.57	2.40	090
27330		A	Biopsy, knee joint lining	5.02	NA	4.80	0.70	090
27331		A	Explore/treat knee joint	5.93	NA	5.76	0.89	090
27332		A	Removal of knee cartilage	8.34	NA	7.46	1.24	090
27333		A	Removal of knee cartilage	7.43	NA	6.92	1.11	090
27334		A	Remove knee joint lining	9.07	NA	7.81	1.35	090
27335		A	Remove knee joint lining	10.43	NA	8.51	1.56	090
27340		A	Removal of kneecap bursa	4.23	NA	4.83	0.63	090
27345		A	Removal of knee cyst	5.98	NA	5.89	0.89	090
27347		A	Remove knee cyst	6.58	NA	6.32	0.98	090
27350		A	Removal of kneecap	8.54	NA	7.56	1.28	090
27355		A	Remove femur lesion	7.89	NA	6.97	1.18	090
27356		A	Remove femur lesion/graft	9.97	NA	8.27	1.49	090
27357		A	Remove femur lesion/graft	11.02	NA	9.05	1.65	090
27358		A	Remove femur lesion/fixation	4.73	NA	2.33	0.71	ZZZ
27360		A	Partial removal, leg bone(s)	11.34	NA	9.72	1.70	090
27365		A	Extensive leg surgery	17.93	NA	12.71	2.69	090
27370		A	Injection for knee x-ray	0.96	3.32	0.43	0.10	000
27372		A	Removal of foreign body	5.12	9.74	4.87	0.76	090
27380		A	Repair of kneecap tendon	7.34	NA	7.26	1.09	090
27381		A	Repair/graft kneecap tendon	10.64	NA	9.14	1.59	090
27385		A	Repair of thigh muscle	8.00	NA	7.60	1.19	090
27386		A	Repair/graft of thigh muscle	10.99	NA	9.56	1.64	090
27390		A	Incision of thigh tendon	5.44	NA	5.53	0.81	090
27391		A	Incision of thigh tendons	7.38	NA	6.77	1.10	090
27392		A	Incision of thigh tendons	9.51	NA	8.04	1.42	090
27393		A	Lengthening of thigh tendon	6.50	NA	6.02	0.97	090
27394		A	Lengthening of thigh tendons	8.68	NA	7.47	1.28	090
27395		A	Lengthening of thigh tendons	12.10	NA	9.59	1.81	090
27396		A	Transplant of thigh tendon	8.04	NA	7.10	1.20	090
27397		A	Transplants of thigh tendons	12.46	NA	10.09	1.87	090
27400		A	Revise thigh muscles/tendons	9.21	NA	7.89	1.38	090
27403		A	Repair of knee cartilage	8.51	NA	7.33	1.27	090
27405		A	Repair of knee ligament	8.96	NA	7.75	1.34	090
27407		A	Repair of knee ligament	10.71	NA	8.82	1.60	090
27409		A	Repair of knee ligaments	13.57	NA	10.32	2.03	090
27412		A	Autochondrocyte implant knee	24.53	NA	16.67	3.67	090
27415		A	Osteochondral knee allograft	19.79	NA	14.31	2.96	090
27416		A	Osteochondral knee autograft	14.00	NA	10.28	2.10	090
27418		A	Repair degenerated kneecap	11.46	NA	9.12	1.70	090
27420		A	Revision of unstable kneecap	10.14	NA	8.33	1.51	090
27422		A	Revision of unstable kneecap	10.09	NA	8.34	1.51	090
27424		A	Revision/removal of kneecap	10.12	NA	8.34	1.51	090
27425		A	Lat retinacular release open	5.28	NA	5.63	0.79	090
27427		A	Reconstruction, knee	9.67	NA	8.14	1.44	090
27428		A	Reconstruction, knee	15.33	NA	12.13	2.29	090
27429		A	Reconstruction, knee	17.24	NA	13.60	2.58	090
27430		A	Revision of thigh muscles	10.04	NA	8.30	1.50	090
27435		A	Incision of knee joint	10.68	NA	9.26	1.60	090
27437		A	Revise kneecap	8.82	NA	7.47	1.32	090
27438		A	Revise kneecap with implant	11.77	NA	9.14	1.76	090
27440		A	Revision of knee joint	10.97	NA	8.75	1.64	090
27441		A	Revision of knee joint	11.42	NA	8.97	1.71	090
27442		A	Revision of knee joint	12.25	NA	9.41	1.83	090
27443		A	Revision of knee joint	11.29	NA	8.90	1.69	090
27445		A	Revision of knee joint	18.52	NA	12.81	2.77	090
27446		A	Revision of knee joint	16.26	NA	11.37	2.43	090
27447		A	Total knee arthroplasty	23.04	NA	15.46	3.44	090
27448		A	Incision of thigh	11.48	NA	8.78	1.73	090
27450		A	Incision of thigh	14.47	NA	10.81	2.17	090
27454		A	Realignment of thigh bone	18.97	NA	13.29	2.84	090
27455		A	Realignment of knee	13.24	NA	10.11	1.98	090
27457		A	Realignment of knee	13.92	NA	10.00	2.08	090
27465		A	Shortening of thigh bone	18.44	NA	12.73	2.76	090
27466		A	Lengthening of thigh bone	17.13	NA	12.41	2.56	090
27468		A	Shorten/lengthen thighs	19.82	NA	13.61	2.97	090
27470		A	Repair of thigh	16.97	NA	12.39	2.53	090
27472		A	Repair/graft of thigh	18.57	NA	13.00	2.78	090
27475		A	Surgery to stop leg growth	8.82	NA	7.48	1.32	090
27477		A	Surgery to stop leg growth	10.03	NA	8.07	1.50	090
27479		A	Surgery to stop leg growth	13.04	NA	6.99	0.70	090
27485		A	Surgery to stop leg growth	9.02	NA	7.51	1.35	090
27486		A	Revise/replace knee joint	20.92	NA	14.27	3.12	090
27487		A	Revise/replace knee joint	26.91	NA	17.24	4.02	090
27488		A	Removal of knee prosthesis	17.40	NA	12.52	2.60	090
27495		A	Reinforce thigh	16.40	NA	11.73	2.45	090
27496		A	Decompression of thigh/knee	6.66	NA	6.63	1.00	090
27497		A	Decompression of thigh/knee	7.70	NA	6.64	1.15	090
27498		A	Decompression of thigh/knee	8.54	NA	7.56	1.28	090
27499		A	Decompression of thigh/knee	9.31	NA	7.94	1.39	090
27500		A	Treatment of thigh fracture	6.21	6.55	5.63	0.91	090
27501		A	Treatment of thigh fracture	6.34	6.02	5.92	0.94	090
27502		A	Treatment of thigh fracture	11.24	NA	8.22	1.65	090

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[4] Global totals for malpractice RVUs may not sum due to rounding.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
27503		A	Treatment of thigh fracture	11.13	NA	8.74	1.66	090
27506		A	Treatment of thigh fracture	19.42	NA	13.87	2.90	090
27507		A	Treatment of thigh fracture	14.39	NA	9.95	2.15	090
27508		A	Treatment of thigh fracture	6.08	6.81	6.07	0.89	090
27509		A	Treatment of thigh fracture	8.02	NA	7.85	1.20	090
27510		A	Treatment of thigh fracture	9.68	NA	7.51	1.41	090
27511		A	Treatment of thigh fracture	14.97	NA	9.93	2.23	090
27513		A	Treatment of thigh fracture	19.11	NA	11.96	2.85	090
27514		A	Treatment of thigh fracture	14.46	NA	9.67	2.16	090
27516		A	Treat thigh fx growth plate	5.45	6.87	6.13	0.82	090
27517		A	Treat thigh fx growth plate	8.98	NA	7.87	1.34	090
27519		A	Treat thigh fx growth plate	13.11	NA	9.01	1.96	090
27520		A	Treat kneecap fracture	2.93	4.86	4.19	0.43	090
27524		A	Treat kneecap fracture	10.25	NA	8.40	1.53	090
27530		A	Treat knee fracture	3.97	5.72	5.07	0.58	090
27532		A	Treat knee fracture	7.43	7.68	6.78	1.11	090
27535		A	Treat knee fracture	13.27	NA	9.09	1.98	090
27536		A	Treat knee fracture	17.19	NA	12.43	2.56	090
27538		A	Treat knee fracture(s)	4.95	6.49	5.78	0.73	090
27540		A	Treat knee fracture	11.16	NA	8.98	1.66	090
27550		A	Treat knee dislocation	5.84	6.28	5.43	0.80	090
27552		A	Treat knee dislocation	8.04	NA	7.35	1.20	090
27556		A	Treat knee dislocation	12.86	NA	8.89	1.92	090
27557		A	Treat knee dislocation	15.76	NA	10.32	2.36	090
27558		A	Treat knee dislocation	18.25	NA	11.54	2.73	090
27560		A	Treat kneecap dislocation	3.88	5.33	4.70	0.58	090
27562		A	Treat kneecap dislocation	5.86	NA	5.94	0.88	090
27566		A	Treat kneecap dislocation	12.59	NA	9.56	1.88	090
27570		A	Fixation of knee joint	1.76	NA	1.93	0.26	010
27580		A	Fusion of knee	20.90	NA	14.99	3.11	090
27590		A	Amputate leg at thigh	13.35	NA	7.37	2.21	090
27591		A	Amputate leg at thigh	13.82	NA	8.76	2.19	090
27592		A	Amputate leg at thigh	10.86	NA	6.58	1.78	090
27594		A	Amputation follow-up surgery	7.17	NA	5.67	1.16	090
27596		A	Amputation follow-up surgery	11.15	NA	7.23	1.81	090
27598		A	Amputate lower leg at knee	11.08	NA	7.63	1.76	090
27599		C	Leg surgery procedure	0.00	0.00	0.00	0.00	YYY
27600		A	Decompression of lower leg	5.94	NA	4.47	0.95	090
27601		A	Decompression of lower leg	5.94	NA	5.09	0.95	090
27602		A	Decompression of lower leg	7.71	NA	5.02	1.30	090
27603		A	Drain lower leg lesion	5.12	8.22	4.67	0.74	090
27604		A	Drain lower leg bursa	4.51	7.38	3.95	0.53	090
27605		A	Incision of achilles tendon	2.89	5.79	1.93	0.26	010
27606		A	Incision of achilles tendon	4.15	NA	3.09	0.54	010
27607		A	Treat lower leg bone lesion	8.51	NA	6.81	1.18	090
27610		A	Explore/treat ankle joint	9.01	NA	7.30	1.22	090
27612		A	Exploration of ankle joint	8.01	NA	6.06	0.85	090
27613		A	Biopsy lower leg soft tissue	2.19	4.14	1.97	0.18	010
27614		A	Biopsy lower leg soft tissue	5.71	8.79	4.55	0.76	090
27615		A	Remove tumor, lower leg	12.93	NA	8.94	1.95	090
27618		A	Remove lower leg lesion	5.14	7.44	4.53	0.74	090
27619		A	Remove lower leg lesion	8.47	11.62	6.30	1.13	090
27620		A	Explore/treat ankle joint	6.04	NA	5.44	0.78	090
27625		A	Remove ankle joint lining	8.37	NA	6.17	0.95	090
27626		A	Remove ankle joint lining	8.98	NA	6.89	1.14	090
27630		A	Removal of tendon lesion	4.85	9.02	4.32	0.58	090
27635		A	Remove lower leg bone lesion	7.91	NA	6.78	1.11	090
27637		A	Remove/graft leg bone lesion	10.17	NA	8.65	1.52	090
27638		A	Remove/graft leg bone lesion	10.87	NA	8.47	1.63	090
27640		A	Partial removal of tibia	12.10	NA	8.89	1.65	090
27641		A	Partial removal of fibula	9.73	NA	7.24	1.26	090
27645		A	Extensive lower leg surgery	14.78	NA	10.92	2.21	090
27646		A	Extensive lower leg surgery	13.21	NA	10.15	1.98	090
27647		A	Extensive ankle/heel surgery	12.85	NA	6.45	0.91	090
27648		A	Injection for ankle x-ray	0.96	3.21	0.41	0.10	000
27650		A	Repair achilles tendon	9.00	NA	7.69	1.12	090
27652		A	Repair/graft achilles tendon	10.64	NA	7.00	1.11	090
27654		A	Repair of achilles tendon	10.32	NA	7.54	1.11	090
27656		A	Repair leg fascia defect	4.62	10.75	5.06	0.69	090
27658		A	Repair of leg tendon, each	5.03	NA	4.52	0.58	090
27659		A	Repair of leg tendon, each	6.99	NA	5.14	0.72	090
27664		A	Repair of leg tendon, each	4.64	NA	4.42	0.56	090
27665		A	Repair of leg tendons, each	5.46	NA	5.01	0.66	090
27675		A	Repair lower leg tendons	7.24	NA	5.21	0.74	090
27676		A	Repair lower leg tendons	8.61	NA	6.66	1.29	090
27680		A	Release of lower leg tendon	5.79	NA	4.94	0.72	090
27681		A	Release of lower leg tendons	6.94	NA	6.47	1.04	090
27685		A	Revision of lower leg tendon	6.57	10.03	5.21	0.67	090
27686		A	Revise lower leg tendons	7.64	NA	6.14	0.97	090
27687		A	Revision of calf tendon	6.30	NA	5.23	0.73	090
27690		A	Revise lower leg tendon	8.96	NA	7.08	0.98	090
27691		A	Revise lower leg tendon	10.28	NA	8.58	1.35	090
27692		A	Revise additional leg tendon	1.87	NA	0.86	0.25	ZZZ
27695		A	Repair of ankle ligament	6.58	NA	5.63	0.79	090

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[4] Global totals for malpractice RVUs may not sum due to rounding.

CPT[1,5] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
27696		A	Repair of ankle ligaments	8.46	NA	5.66	0.85	090
27698		A	Repair of ankle ligament	9.49	NA	6.78	1.12	090
27700		A	Revision of ankle joint	9.54	NA	5.90	0.89	090
27702		A	Reconstruct ankle joint	14.28	NA	10.21	1.99	090
27703		A	Reconstruction, ankle joint	16.79	NA	11.78	2.40	090
27704		A	Removal of ankle implant	7.69	NA	6.62	1.05	090
27705		A	incision of tibia	10.74	NA	8.31	1.52	090
27707		A	incision of fibula	4.67	NA	5.28	0.67	090
27709		A	Incision of tibia & fibula	17.32	NA	11.99	2.55	090
27712		A	Realignment of lower leg	15.67	NA	11.68	2.35	090
27715		A	Revision of lower leg	15.36	NA	11.20	2.30	090
27720		A	Repair of tibia	12.22	NA	9.60	1.81	090
27722		A	Repair/graft of tibia	12.31	NA	9.70	1.84	090
27724		A	Repair/graft of tibia	19.18	NA	12.59	2.85	090
27725		A	Repair of lower leg	17.15	NA	12.97	2.57	090
27726		A	Repair fibula nonunion	14.20	NA	10.09	2.09	090
27727		A	Repair of lower leg	14.69	NA	11.00	2.20	090
27730		A	Repair of tibia epiphysis	7.59	NA	6.81	1.14	090
27732		A	Repair of fibula epiphysis	5.37	NA	5.57	0.29	090
27734		A	Repair lower leg epiphyses	8.72	NA	5.28	0.47	090
27740		A	Repair of leg epiphyses	9.49	NA	7.97	1.42	090
27742		A	Repair of leg epiphyses	10.49	NA	8.70	1.57	090
27745		A	Reinforce tibia	10.37	NA	8.42	1.55	090
27750		A	Treatment of tibia fracture	3.26	5.13	4.45	0.47	090
27752		A	Treatment of tibia fracture	6.15	7.04	6.07	0.91	090
27756		A	Treatment of tibia fracture	7.33	NA	6.86	1.09	090
27758		A	Treatment of tibia fracture	12.40	NA	9.73	1.85	090
27759		A	Treatment of tibia fracture	14.31	NA	10.55	2.13	090
27760		A	Clx medial ankle fx	3.09	5.03	4.33	0.42	090
27762		A	Clx med ankle fx w/mnpj	5.33	6.42	5.47	0.74	090
27766		A	Optx medial ankle fx	7.73	NA	7.31	1.11	090
27767		A	Clx post ankle fx	2.50	4.30	4.34	0.36	090
27768		A	Clx post ankle fx w/mnpj	5.00	NA	5.67	0.75	090
27769		A	Optx post ankle fx	10.00	NA	8.18	1.50	090
27780		A	Treatment of fibula fracture	2.72	4.64	3.99	0.39	090
27781		A	Treatment of fibula fracture	4.47	5.94	5.21	0.65	090
27784		A	Treatment of fibula fracture	9.51	NA	8.23	1.40	090
27786		A	Treatment of ankle fracture	2.91	4.79	4.07	0.41	090
27788		A	Treatment of ankle fracture	4.52	5.82	4.96	0.63	090
27792		A	Treatment of ankle fracture	9.55	NA	8.13	1.37	090
27808		A	Treatment of ankle fracture	2.91	5.16	4.36	0.41	090
27810		A	Treatment of ankle fracture	5.20	6.34	5.35	0.74	090
27814		A	Treatment of ankle fracture	10.46	NA	8.73	1.54	090
27816		A	Treatment of ankle fracture	2.96	4.76	3.98	0.40	090
27818		A	Treatment of ankle fracture	5.57	6.29	5.15	0.77	090
27822		A	Treatment of ankle fracture	11.03	NA	9.85	1.62	090
27823		A	Treatment of ankle fracture	12.98	NA	10.79	1.90	090
27824		A	Treat lower leg fracture	3.20	4.39	4.18	0.45	090
27825		A	Treat lower leg fracture	6.60	6.92	5.73	0.95	090
27826		A	Treat lower leg fracture	10.92	NA	9.79	1.59	090
27827		A	Treat lower leg fracture	14.56	NA	12.24	2.15	090
27828		A	Treat lower leg fracture	18.20	NA	14.08	2.70	090
27829		A	Treat lower leg joint	8.64	NA	8.36	1.26	090
27830		A	Treat lower leg dislocation	3.85	5.36	4.74	0.58	090
27831		A	Treat lower leg dislocation	4.62	NA	5.11	0.69	090
27832		A	Treat lower leg dislocation	10.01	NA	8.59	1.50	090
27840		A	Treat ankle dislocation	4.65	NA	4.25	0.61	090
27842		A	Treat ankle dislocation	6.34	NA	5.78	0.90	090
27846		A	Treat ankle dislocation	10.16	NA	8.15	1.46	090
27848		A	Treat ankle dislocation	11.56	NA	8.93	1.69	090
27860		A	Fixation of ankle joint	2.36	NA	2.00	0.28	010
27870		A	Fusion of ankle joint, open	15.21	NA	10.88	2.10	090
27871		A	Fusion of tibiofibular joint	9.42	NA	7.86	1.39	090
27880		A	Amputation of lower leg	15.24	NA	8.24	2.50	090
27881		A	Amputation of lower leg	13.32	NA	8.88	2.10	090
27882		A	Amputation of lower leg	9.67	NA	5.86	1.61	090
27884		A	Amputation follow-up surgery	8.64	NA	6.04	1.40	090
27886		A	Amputation follow-up surgery	9.88	NA	6.90	1.59	090
27888		A	Amputation of foot at ankle	10.23	NA	7.18	1.46	090
27889		A	Amputation of foot at ankle	10.72	NA	6.02	1.80	090
27892		A	Decompression of leg	7.82	NA	6.03	1.23	090
27893		A	Decompression of leg	7.78	NA	5.92	1.26	090
27894		A	Decompression of leg	12.42	NA	8.82	1.98	090
27899		C	Leg/ankle surgery procedure	0.00	0.00	0.00	0.00	YYY
28001		A	Drainage of bursa of foot	2.75	4.26	1.67	0.16	010
28002		A	Treatment of foot infection	5.78	7.34	3.89	0.48	010
28003		A	Treatment of foot infection	8.95	8.48	4.94	0.76	090
28005		A	Treat foot bone lesion	9.30	NA	5.98	0.73	090
28008		A	Incision of foot fascia	4.50	6.48	3.07	0.30	090
28010		A	Incision of toe tendon	2.89	3.04	2.47	0.19	090
28011		A	Incision of toe tendons	4.19	4.21	3.35	0.35	090
28020		A	Exploration of foot joint	5.06	8.26	3.99	0.49	090
28022		A	Exploration of foot joint	4.72	7.44	3.51	0.35	090
28024		A	Exploration of toe joint	4.43	7.06	3.30	0.30	090

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CPT[1,2] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
28035		A	Decompression of tibia nerve	5.14	8.25	4.01	0.48	090
28043		A	Excision of foot lesion	3.58	5.23	2.96	0.27	090
28045		A	Excision of foot lesion	4.77	7.77	3.54	0.37	090
28046		A	Resection of tumor, foot	10.55	11.16	6.20	1.08	090
28050		A	Biopsy of foot joint lining	4.30	6.54	2.98	0.23	090
28052		A	Biopsy of foot joint lining	3.98	7.45	3.38	0.36	090
28054		A	Biopsy of toe joint lining	3.49	6.06	2.61	0.19	090
28055		A	Neurectomy, foot	6.20	NA	3.65	0.39	090
28060		A	Partial removal, foot fascia	5.29	7.77	3.82	0.40	090
28062		A	Removal of foot fascia	6.58	8.36	3.98	0.43	090
28070		A	Removal of foot joint lining	5.15	7.75	3.63	0.41	090
28072		A	Removal of foot joint lining	4.63	8.54	4.04	0.47	090
28080		A	Removal of foot lesion	4.65	8.40	4.54	0.34	090
28086		A	Excise foot tendon sheath	4.83	8.85	4.29	0.54	090
28088		A	Excise foot tendon sheath	3.90	7.78	3.53	0.40	090
28090		A	Removal of foot lesion	4.46	7.45	3.44	0.34	090
28092		A	Removal of toe lesions	3.69	7.10	3.24	0.29	090
28100		A	Removal of ankle/heel lesion	5.72	9.20	4.52	0.57	090
28102		A	Remove/graft foot lesion	7.80	NA	4.16	0.42	090
28103		A	Remove/graft foot lesion	6.56	NA	3.71	0.36	090
28104		A	Removal of foot lesion	5.17	7.86	3.70	0.40	090
28106		A	Remove/graft foot lesion	7.23	NA	4.02	0.39	090
28107		A	Remove/graft foot lesion	5.62	7.62	3.48	0.31	090
28108		A	Removal of toe lesions	4.21	6.88	3.18	0.28	090
28110		A	Part removal of metatarsal	4.13	7.52	3.26	0.30	090
28111		A	Part removal of metatarsal	5.06	7.81	3.50	0.43	090
28112		A	Part removal of metatarsal	4.54	7.85	3.49	0.37	090
28113		A	Part removal of metatarsal	5.88	9.09	4.95	0.44	090
28114		A	Removal of metatarsal heads	11.61	15.44	9.56	1.20	090
28116		A	Revision of foot	8.94	10.13	5.61	0.69	090
28118		A	Removal of heel bone	6.02	8.85	4.45	0.55	090
28119		A	Removal of heel spur	5.45	7.88	3.84	0.39	090
28120		A	Part removal of ankle/heel	5.64	9.26	4.54	0.58	090
28122		A	Partial removal of foot bone	7.56	9.34	5.21	0.59	090
28124		A	Partial removal of toe	4.88	7.24	3.62	0.30	090
28126		A	Partial removal of toe	3.56	6.49	2.84	0.24	090
28130		A	Removal of ankle bone	9.30	NA	6.88	1.39	090
28140		A	Removal of metatarsal	7.03	8.56	4.49	0.67	090
28150		A	Removal of toe	4.14	6.96	3.21	0.31	090
28153		A	Partial removal of toe	3.71	6.82	3.12	0.26	090
28160		A	Partial removal of toe	3.79	6.99	3.19	0.28	090
28171		A	Extensive foot surgery	9.85	NA	5.15	0.53	090
28173		A	Extensive foot surgery	9.05	9.55	5.00	0.73	090
28175		A	Extensive foot surgery	6.17	7.94	3.98	0.43	090
28190		A	Removal of foot foreign body	1.98	4.47	1.48	0.13	010
28192		A	Removal of foot foreign body	4.69	7.30	3.43	0.35	090
28193		A	Removal of foot foreign body	5.79	7.87	3.83	0.41	090
28200		A	Repair of foot tendon	4.65	7.34	3.37	0.33	090
28202		A	Repair/graft of foot tendon	6.96	8.34	4.13	0.47	090
28208		A	Repair of foot tendon	4.42	7.48	3.51	0.35	090
28210		A	Repair/graft of foot tendon	6.41	8.18	4.13	0.44	090
28220		A	Release of foot tendon	4.58	6.89	3.23	0.30	090
28222		A	Release of foot tendons	5.67	7.35	3.45	0.36	090
28225		A	Release of foot tendons	3.70	6.44	2.84	0.25	090
28226		A	Release of foot tendons	4.58	6.71	3.05	0.25	090
28230		A	Incision of foot tendon(s)	4.28	6.69	3.00	0.28	090
28232		A	Incision of toe tendon	3.43	6.44	2.85	0.24	090
28234		A	Incision of foot tendon	3.43	6.94	3.33	0.25	090
28238		A	Revision of foot tendon	7.85	9.41	4.83	0.63	090
28240		A	Release of big toe	4.40	6.93	3.16	0.32	090
28250		A	Revision of foot fascia	5.97	8.58	4.30	0.57	090
28260		A	Release of midfoot joint	8.08	9.77	5.30	0.77	090
28261		A	Revision of foot tendon	12.91	11.38	6.59	0.92	090
28262		A	Revision of foot and ankle	17.01	18.25	11.57	2.31	090
28264		A	Release of midfoot joint	10.53	8.89	4.85	0.57	090
28270		A	Release of foot contracture	4.82	7.61	3.73	0.36	090
28272		A	Release of toe joint, each	3.84	6.20	2.75	0.22	090
28280		A	Fusion of toes	5.24	7.98	3.81	0.42	090
28285		A	Repair of hammertoe	4.65	7.32	3.59	0.33	090
28286		A	Repair of hammertoe	4.61	6.97	3.18	0.28	090
28288		A	Partial removal of foot bone	5.81	9.51	5.14	0.48	090
28289		A	Repair hallux rigidus	8.11	10.49	5.88	0.72	090
28290		A	Correction of bunion	5.72	9.10	4.35	0.52	090
28292		A	Correction of bunion	8.72	11.28	6.62	0.61	090
28293		A	Correction of bunion	11.10	15.38	7.16	0.66	090
28294		A	Correction of bunion	8.63	10.44	5.17	0.69	090
28296		A	Correction of bunion	8.16	10.05	5.30	0.55	090
28297		A	Correction of bunion	9.31	11.67	5.88	0.86	090
28298		A	Correction of bunion	8.01	10.35	5.03	0.63	090
28299		A	Correction of bunion	11.39	11.52	6.12	0.81	090
28300		A	Incision of heel bone	9.61	NA	7.04	1.20	090
28302		A	Incision of ankle bone	9.62	NA	8.03	1.44	090
28304		A	Incision of midfoot bones	9.29	10.99	5.82	0.87	090
28305		A	Incise/graft midfoot bones	10.63	NA	6.72	0.58	090

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
28306		A	Incision of metatarsal	5.91	9.77	4.50	0.61	090
28307		A	Incision of metatarsal	6.39	12.88	6.20	0.96	090
28308		A	Incision of metatarsal	5.36	8.89	4.24	0.43	090
28309		A	Incision of metatarsals	13.96	NA	8.82	1.57	090
28310		A	Revision of big toe	5.48	8.19	3.63	0.39	090
28312		A	Revision of toe	4.60	8.19	3.53	0.36	090
28313		A	Repair deformity of toe	5.06	8.50	4.20	0.53	090
28315		A	Removal of sesamoid bone	4.91	7.27	3.44	0.35	090
28320		A	Repair of foot bones	9.25	NA	6.45	1.04	090
28322		A	Repair of metatarsals	8.41	11.55	6.33	0.97	090
28340		A	Resect enlarged toe tissue	7.04	7.93	3.83	0.38	090
28341		A	Resect enlarged toe	8.60	8.83	4.38	0.47	090
28344		A	Repair extra toe(s)	4.31	6.62	2.98	0.23	090
28345		A	Repair webbed toe(s)	5.98	7.47	3.57	0.32	090
28360		A	Reconstruct cleft foot	14.67	NA	9.79	2.38	090
28400		A	Treatment of heel fracture	2.22	3.91	3.39	0.27	090
28405		A	Treatment of heel fracture	4.63	4.99	4.14	0.50	090
28406		A	Treatment of heel fracture	6.44	NA	6.51	0.88	090
28415		A	Treat heel fracture	15.96	NA	12.04	2.09	090
28420		A	Treat graft heel fracture	17.29	NA	13.70	2.59	090
28430		A	Treatment of ankle fracture	2.14	3.64	3.01	0.26	090
28435		A	Treatment of ankle fracture	3.45	5.29	4.37	0.52	090
28436		A	Treatment of ankle fracture	4.78	NA	6.14	0.72	090
28445		A	Treat ankle fracture	15.53	NA	11.23	2.08	090
28446		A	Osteochondral talus autograft	17.50	NA	12.84	2.62	090
28450		A	Treat midfoot fracture, each	1.95	3.37	2.80	0.22	090
28455		A	Treat midfoot fracture, each	3.15	4.40	3.64	0.33	090
28456		A	Treat midfoot fracture	2.75	NA	5.13	0.41	090
28465		A	Treat midfoot fracture, each	8.64	NA	6.77	0.94	090
28470		A	Treat metatarsal fracture	1.99	3.28	2.76	0.24	090
28475		A	Treat metatarsal fracture	2.97	3.50	2.80	0.29	090
28476		A	Treat metatarsal fracture	3.46	NA	4.92	0.39	090
28485		A	Treat metatarsal fracture	7.28	NA	6.23	0.70	090
28490		A	Treat big toe fracture	1.12	2.45	1.96	0.12	090
28495		A	Treat big toe fracture	1.62	2.77	2.09	0.13	090
28496		A	Treat big toe fracture	2.39	8.24	3.31	0.26	090
28505		A	Treat big toe fracture	7.28	9.55	5.41	0.68	090
28510		A	Treatment of toe fracture	1.12	1.93	1.85	0.11	090
28515		A	Treatment of toe fracture	1.50	2.50	2.04	0.13	090
28525		A	Treat toe fracture	5.46	8.89	4.69	0.52	090
28530		A	Treat sesamoid bone fracture	1.08	1.84	1.51	0.08	090
28531		A	Treat sesamoid bone fracture	2.51	9.23	3.51	0.14	090
28540		A	Treat foot dislocation	2.10	2.95	2.46	0.14	090
28545		A	Treat foot dislocation	2.51	4.63	3.81	0.38	090
28546		A	Treat foot dislocation	3.28	10.69	4.91	0.49	090
28555		A	Repair foot dislocation	9.49	12.50	7.31	1.17	090
28570		A	Treat foot dislocation	1.70	2.42	1.85	0.09	090
28575		A	Treat foot dislocation	3.38	5.44	4.60	0.51	090
28576		A	Treat foot dislocation	4.48	NA	5.14	0.67	090
28585		A	Repair foot dislocation	10.92	13.13	7.90	1.22	090
28600		A	Treat foot dislocation	1.94	3.47	2.72	0.21	090
28605		A	Treat foot dislocation	2.78	5.10	4.31	0.42	090
28606		A	Treat foot dislocation	4.97	NA	4.85	0.64	090
28615		A	Repair foot dislocation	10.46	NA	9.07	1.29	090
28630		A	Treat toe dislocation	1.72	2.16	1.07	0.15	010
28635		A	Treat toe dislocation	1.93	2.45	1.41	0.15	010
28636		A	Treat toe dislocation	2.77	4.96	2.31	0.31	010
28645		A	Repair toe dislocation	7.28	9.11	4.97	0.59	090
28660		A	Treat toe dislocation	1.25	1.59	0.96	0.12	010
28665		A	Treat toe dislocation	1.94	2.04	1.47	0.17	010
28666		A	Treat toe dislocation	2.66	NA	2.60	0.40	010
28675		A	Repair of toe dislocation	5.46	9.29	4.98	0.56	090
28705		A	Fusion of foot bones	20.12	NA	12.69	2.59	090
28715		A	Fusion of foot bones	14.40	NA	10.04	1.86	090
28725		A	Fusion of foot bones	11.97	NA	7.86	1.40	090
28730		A	Fusion of foot bones	12.21	NA	9.02	1.43	090
28735		A	Fusion of foot bones	12.03	NA	8.04	1.30	090
28737		A	Revision of foot bones	10.83	NA	6.56	0.93	090
28740		A	Fusion of foot bones	9.09	12.51	6.89	0.99	090
28750		A	Fusion of big toe joint	8.37	12.45	6.80	0.96	090
28755		A	Fusion of big toe joint	4.79	7.97	3.62	0.38	090
28760		A	Fusion of big toe joint	8.94	11.23	5.93	0.76	090
28800		A	Amputation of midfoot	8.65	NA	5.61	0.98	090
28805		A	Amputation thru metatarsal	12.55	NA	6.68	1.58	090
28810		A	Amputation toe & metatarsal	6.52	NA	4.66	0.87	090
28820		A	Amputation of toe	4.89	8.42	3.94	0.54	090
28825		A	Partial amputation of toe	5.85	8.90	4.55	0.62	090
28890		A	High energy eswt, plantar f	3.36	5.27	2.52	0.26	090
28899		C	Foot/toes surgery procedure	0.00	0.00	0.00	0.00	YYY
29000		A	Application of body cast	2.25	3.63	1.77	0.13	000
29010		A	Application of body cast	2.06	2.36	0.86	0.31	000
29015		A	Application of body cast	2.41	3.74	1.36	0.25	000
29020		A	Application of body cast	2.11	3.34	1.29	0.07	000
29025		A	Application of body cast	2.40	4.77	2.13	0.13	000

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
29035		A	Application of body cast	1.77	4.03	1.66	0.26	000
29040		A	Application of body cast	2.22	3.80	1.68	0.33	000
29044		A	Application of body cast	2.12	4.27	1.84	0.32	000
29046		A	Application of body cast	2.41	4.33	1.93	0.36	000
29049		A	Application of figure eight	0.89	1.12	0.63	0.13	000
29055		A	Application of shoulder cast	1.78	3.66	1.67	0.27	000
29058		A	Application of shoulder cast	1.31	1.51	0.70	0.14	000
29065		A	Application of long arm cast	0.87	1.51	0.85	0.12	000
29075		A	Application of forearm cast	0.77	1.46	0.80	0.11	000
29085		A	Apply hand/wrist cast	0.87	1.50	0.84	0.11	000
29086		A	Apply finger cast	0.62	1.33	0.70	0.06	000
29105		A	Apply long arm splint	0.87	1.31	0.66	0.10	000
29125		A	Apply forearm splint	0.59	1.17	0.53	0.06	000
29126		A	Apply forearm splint	0.77	1.23	0.61	0.08	000
29130		A	Application of finger splint	0.50	0.53	0.24	0.05	000
29131		A	Application of finger splint	0.55	0.74	0.31	0.05	000
29200		A	Strapping of chest	0.65	0.77	0.44	0.03	000
29220		A	Strapping of low back	0.64	0.77	0.45	0.03	000
29240		A	Strapping of shoulder	0.71	0.76	0.44	0.04	000
29260		A	Strapping of elbow or wrist	0.55	0.77	0.43	0.04	000
29280		A	Strapping of hand or finger	0.51	0.77	0.43	0.03	000
29305		A	Application of hip cast	2.03	4.02	1.94	0.30	000
29325		A	Application of hip casts	2.32	4.39	2.14	0.35	000
29345		A	Application of long leg cast	1.40	1.97	1.14	0.20	000
29355		A	Application of long leg cast	1.53	1.96	1.15	0.21	000
29358		A	Apply long leg cast brace	1.43	2.51	1.17	0.21	000
29365		A	Application of long leg cast	1.18	1.85	1.02	0.17	000
29405		A	Apply short leg cast	0.86	1.39	0.77	0.11	000
29425		A	Apply short leg cast	1.01	1.40	0.75	0.10	000
29435		A	Apply short leg cast	1.18	1.77	0.96	0.16	000
29440		A	Addition of walker to cast	0.57	0.77	0.32	0.07	000
29445		A	Apply rigid leg cast	1.78	1.80	1.03	0.17	000
29450		A	Application of leg cast	2.08	1.67	0.92	0.15	000
29505		A	Application, long leg splint	0.69	1.31	0.57	0.07	000
29515		A	Application lower leg splint	0.73	1.14	0.55	0.07	000
29520		A	Strapping of hip	0.54	0.72	0.40	0.03	000
29530		A	Strapping of knee	0.57	0.76	0.42	0.04	000
29540		A	Strapping of ankle and/or ft	0.51	0.58	0.32	0.03	000
29550		A	Strapping of toes	0.47	0.60	0.31	0.03	000
29580		A	Application of paste boot	0.55	0.80	0.38	0.05	000
29590		A	Application of foot splint	0.76	0.64	0.26	0.04	000
29700		A	Removal/revision of cast	0.57	1.05	0.30	0.07	000

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
29705		A	Removal/revision of cast	0.76	0.92	0.45	0.10	000
29710		A	Removal/revision of cast	1.34	1.71	0.77	0.20	000
29715		A	Removal/revision of cast	0.94	1.09	0.43	0.06	000
29720		A	Repair of body cast	0.68	1.37	0.42	0.10	000
29730		A	Windowing of cast	0.75	0.89	0.42	0.09	000
29740		A	Wedging of cast	1.12	1.14	0.52	0.13	000
29750		A	Wedging of clubfoot cast	1.26	1.40	0.71	0.19	000
29799		C	Casting/strapping procedure	0.00	0.00	0.00	0.00	YYY
29800		A	Jaw arthroscopy/surgery	6.73	NA	6.22	1.01	090
29804		A	Jaw arthroscopy/surgery	8.71	NA	6.23	0.24	090
29805		A	Shoulder arthroscopy, dx	5.94	NA	5.66	0.88	090
29806		A	Shoulder arthroscopy/surgery	14.95	NA	11.36	2.22	090
29807		A	Shoulder arthroscopy/surgery	14.48	NA	11.16	2.15	090
29819		A	Shoulder arthroscopy/surgery	7.68	NA	6.79	1.14	090
29820		A	Shoulder arthroscopy/surgery	7.12	NA	6.23	1.06	090
29821		A	Shoulder arthroscopy/surgery	7.78	NA	6.85	1.16	090
29822		A	Shoulder arthroscopy/surgery	7.49	NA	6.73	1.11	090
29823		A	Shoulder arthroscopy/surgery	8.24	NA	7.31	1.23	090
29824		A	Shoulder arthroscopy/surgery	8.82	NA	7.91	1.31	090
29825		A	Shoulder arthroscopy/surgery	7.68	NA	6.81	1.14	090
29826		A	Shoulder arthroscopy/surgery	9.05	NA	7.50	1.35	090
29827		A	Arthroscop rotator cuff repr	15.44	NA	11.36	2.29	090
29828		A	Arthroscopy biceps tenodesis	13.00	NA	9.98	1.94	090
29830		A	Elbow arthroscopy	5.80	NA	5.39	0.87	090
29834		A	Elbow arthroscopy/surgery	6.33	NA	5.87	0.92	090
29835		A	Elbow arthroscopy/surgery	6.53	NA	5.97	0.98	090
29836		A	Elbow arthroscopy/surgery	7.61	NA	6.78	1.14	090
29837		A	Elbow arthroscopy/surgery	6.92	NA	6.18	1.02	090
29838		A	Elbow arthroscopy/surgery	7.77	NA	6.86	1.12	090
29840		A	Wrist arthroscopy	5.59	NA	5.51	0.84	090
29843		A	Wrist arthroscopy/surgery	6.06	NA	5.83	0.91	090
29844		A	Wrist arthroscopy/surgery	6.42	NA	5.99	0.89	090
29845		A	Wrist arthroscopy/surgery	7.58	NA	6.61	1.03	090
29846		A	Wrist arthroscopy/surgery	6.80	NA	6.18	0.92	090
29847		A	Wrist arthroscopy/surgery	7.13	NA	6.26	1.07	090
29848		A	Wrist endoscopy/surgery	6.24	NA	6.35	0.87	090
29850		A	Knee arthroscopy/surgery	8.18	NA	7.23	1.32	090
29851		A	Knee arthroscopy/surgery	13.08	NA	9.96	1.96	090
29855		A	Tibial arthroscopy/surgery	10.60	NA	8.84	1.59	090
29856		A	Tibial arthroscopy/surgery	14.12	NA	10.57	2.11	090
29860		A	Hip arthroscopy, dx	8.85	NA	7.56	1.32	090
29861		A	Hip arthroscopy/surgery	9.95	NA	8.10	1.49	090

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29862		A	Hip arthroscopy/surgery	10.97	NA	9.20	1.63	090
29863		A	Hip arthroscopy/surgery	10.97	NA	9.24	1.64	090
29866		A	Autgrft implnt, knee w/scope	14.48	NA	11.46	2.17	090
29867		A	Allgrft implnt, knee w/scope	18.18	NA	13.52	2.72	090
29868		A	Meniscal trnspl, knee w/scpe	24.89	NA	16.82	3.73	090
29870		A	Knee arthroscopy, dx	5.11	NA	5.03	0.76	090
29871		A	Knee arthroscopy/drainage	6.60	NA	6.08	0.98	090
29873		A	Knee arthroscopy/surgery	6.09	NA	6.70	0.91	090
29874		A	Knee arthroscopy/surgery	7.10	NA	6.19	1.05	090
29875		A	Knee arthroscopy/surgery	6.36	NA	5.87	0.95	090
29876		A	Knee arthroscopy/surgery	8.72	NA	7.46	1.30	090
29877		A	Knee arthroscopy/surgery	8.15	NA	7.19	1.22	090
29879		A	Knee arthroscopy/surgery	8.84	NA	7.52	1.32	090
29880		A	Knee arthroscopy/surgery	9.30	NA	7.75	1.39	090
29881		A	Knee arthroscopy/surgery	8.56	NA	7.39	1.28	090
29882		A	Knee arthroscopy/surgery	9.45	NA	7.79	1.41	090
29883		A	Knee arthroscopy/surgery	11.61	NA	9.19	1.73	090
29884		A	Knee arthroscopy/surgery	8.13	NA	7.19	1.22	090
29885		A	Knee arthroscopy/surgery	10.03	NA	8.49	1.50	090
29886		A	Knee arthroscopy/surgery	8.34	NA	7.31	1.25	090
29887		A	Knee arthroscopy/surgery	9.98	NA	8.43	1.49	090
29888		A	Knee arthroscopy/surgery	14.14	NA	10.49	2.11	090
29889		A	Knee arthroscopy/surgery	17.15	NA	12.98	2.54	090
29891		A	Ankle arthroscopy/surgery	9.47	NA	7.78	1.23	090
29892		A	Ankle arthroscopy/surgery	10.07	NA	8.81	1.51	090
29893		A	Scope, plantar fasciotomy	6.08	9.36	4.84	0.35	090
29894		A	Ankle arthroscopy/surgery	7.26	NA	5.64	0.91	090
29895		A	Ankle arthroscopy/surgery	7.04	NA	5.31	0.84	090
29897		A	Ankle arthroscopy/surgery	7.23	NA	5.73	0.92	090
29898		A	Ankle arthroscopy/surgery	8.38	NA	6.08	0.96	090
29899		A	Ankle arthroscopy/surgery	15.21	NA	10.90	2.15	090
29900		A	Mcp joint arthroscopy, dx	5.74	NA	4.42	0.31	090
29901		A	Mcp joint arthroscopy, surg	6.45	NA	6.58	0.97	090
29902		A	Mcp joint arthroscopy, surg	7.02	NA	8.04	1.91	090
29904		A	Subtalar arthro w/fb rmvl	8.50	NA	7.19	1.27	090
29905		A	Subtalar arthro w/exc	9.00	NA	7.94	1.35	090
29906		A	Subtalar arthro w/deb	9.47	NA	8.38	1.42	090
29907		A	Subtalar arthro w/fusion	12.00	NA	9.63	0.65	090
29999		C	Arthroscopy of joint	0.00	0.00	0.00	0.00	YYY
30000		A	Drainage of nose lesion	1.45	4.37	1.57	0.10	010
30020		A	Drainage of nose lesion	1.45	4.40	1.60	0.10	010
30100		A	Intranasal biopsy	0.94	2.67	0.85	0.06	000
30110		A	Removal of nose polyp(s)	1.65	4.16	1.69	0.11	010
30115		A	Removal of nose polyp(s)	4.38	NA	6.61	0.43	090
30117		A	Removal of intranasal lesion	3.20	18.65	5.37	0.31	090
30118		A	Removal of intranasal lesion	9.81	NA	9.80	0.98	090
30120		A	Revision of nose	5.31	7.75	5.78	0.63	090
30124		A	Removal of nose lesion	3.14	NA	3.85	0.32	090
30125		A	Removal of nose lesion	7.21	NA	8.40	0.70	090
30130		A	Excise inferior turbinate	3.41	NA	6.25	0.32	090
30140		A	Resect inferior turbinate	3.48	NA	7.61	0.34	090
30150		A	Partial removal of nose	9.44	NA	10.28	1.06	090
30160		A	Removal of nose	9.88	NA	10.05	0.96	090
3018F		I	Pre-prvd rsk st al docd	0.00	0.00	0.00	0.00	XXX
30200		A	Injection treatment of nose	0.78	2.13	0.78	0.05	000
30210		A	Nasal sinus therapy	1.10	2.68	1.43	0.07	010
30220		A	Insert nasal septal button	1.56	6.07	1.65	0.10	010
30300		A	Remove nasal foreign body	1.06	4.71	2.13	0.07	010
30310		A	Remove nasal foreign body	1.98	NA	3.26	0.13	010
30320		A	Remove nasal foreign body	4.56	NA	6.93	0.44	090
30400		R	Reconstruction of nose	10.58	NA	14.97	1.03	090
30410		R	Reconstruction of nose	13.72	NA	16.45	1.34	090
30420		R	Reconstruction of nose	16.62	NA	18.32	1.78	090
30430		R	Revision of nose	7.96	NA	13.74	1.19	090
30435		R	Revision of nose	12.45	NA	15.85	1.21	090
30450		R	Revision of nose	19.38	NA	19.11	1.89	090
30460		A	Revision of nose	10.24	NA	10.46	1.53	090
30462		A	Revision of nose	20.12	NA	16.22	1.96	090
30465		A	Repair nasal stenosis	12.20	NA	12.92	1.30	090
30520		A	Repair of nasal septum	6.85	NA	9.02	0.67	090
30540		A	Repair nasal defect	7.81	NA	9.79	0.76	090
30545		A	Repair nasal defect	11.50	NA	10.42	0.62	090
30560		A	Release of nasal adhesions	1.28	5.50	2.22	0.09	010
30580		A	Repair upper jaw fistula	6.76	8.66	5.55	0.27	090
30600		A	Repair mouth/nose fistula	6.07	8.54	5.01	0.59	090
30620		A	Intranasal reconstruction	6.04	NA	9.71	0.67	090
30630		A	Repair nasal septum defect	7.18	NA	8.76	0.73	090
30801		A	Ablate inf turbinate, superf	1.11	4.60	2.34	0.07	010
30802		A	Cauterization, inner nose	2.05	5.28	2.81	0.14	010
30901		A	Control of nosebleed	1.21	1.47	0.42	0.10	000
30903		A	Control of nosebleed	1.54	3.57	0.58	0.12	000
30905		A	Control of nosebleed	1.97	4.35	0.69	0.16	000
30906		A	Repeat control of nosebleed	2.45	4.68	1.07	0.17	000
30915		A	Ligation, nasal sinus artery	7.36	NA	7.55	0.73	090

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CPT[1,5] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
30920		A	Ligation, upper jaw artery	11.03	NA	10.50	1.08	090
30930		A	Ther fx, nasal inf turbinate	1.28	NA	1.86	0.08	010
30999		C	Nasal surgery procedure	0.00	0.00	0.00	0.00	YYY
31000		A	Irrigation, maxillary sinus	1.17	3.35	1.48	0.07	010
31002		A	Irrigation, sphenoid sinus	1.93	NA	3.13	0.13	010
31020		A	Exploration, maxillary sinus	2.99	8.92	5.90	0.28	090
31030		A	Exploration, maxillary sinus	5.95	10.77	6.96	0.47	090
31032		A	Explore sinus, remove polyps	6.61	NA	7.82	0.60	090
31040		A	Exploration behind upper jaw	9.66	NA	9.48	0.98	090
31050		A	Exploration, sphenoid sinus	5.31	NA	7.08	0.52	090
31051		A	Sphenoid sinus surgery	7.16	NA	9.34	0.70	090
31070		A	Exploration of frontal sinus	4.32	NA	6.83	0.43	090
31075		A	Exploration of frontal sinus	9.40	NA	10.65	0.92	090
31080		A	Removal of frontal sinus	12.54	NA	13.84	1.22	090
31081		A	Removal of frontal sinus	13.99	NA	20.75	3.80	090
31084		A	Removal of frontal sinus	14.75	NA	14.88	1.44	090
31085		A	Removal of frontal sinus	15.44	NA	21.43	4.20	090
31086		A	Removal of frontal sinus	14.16	NA	14.61	1.38	090
31087		A	Removal of frontal sinus	14.39	NA	13.46	1.40	090
31090		A	Exploration of sinuses	10.88	NA	15.04	1.04	090
31200		A	Removal of ethmoid sinus	5.03	NA	9.03	0.32	090
31201		A	Removal of ethmoid sinus	8.49	NA	10.39	0.78	090
31205		A	Removal of ethmoid sinus	10.47	NA	12.24	0.72	090
31225		A	Removal of upper jaw	26.44	NA	21.54	2.56	090
31230		A	Removal of upper jaw	30.56	NA	23.40	2.98	090
31231		A	Nasal endoscopy, dx	1.10	3.77	0.92	0.07	000
31233		A	Nasal/sinus endoscopy, dx	2.18	4.59	1.43	0.14	000
31235		A	Nasal/sinus endoscopy, dx	2.64	5.03	1.63	0.17	000
31237		A	Nasal/sinus endoscopy, surg	2.98	5.34	1.81	0.20	000
31238		A	Nasal/sinus endoscopy, surg	3.26	5.30	1.94	0.21	000
31239		A	Nasal/sinus endoscopy, surg	9.23	NA	8.44	0.53	010
31240		A	Nasal/sinus endoscopy, surg	2.61	NA	1.63	0.17	000
31254		A	Revision of ethmoid sinus	4.64	NA	2.60	0.31	000
31255		A	Removal of ethmoid sinus	6.95	NA	3.66	0.46	000
31256		A	Exploration maxillary sinus	3.29	NA	1.95	0.22	000
31267		A	Endoscopy, maxillary sinus	5.45	NA	2.97	0.36	000
31276		A	Sinus endoscopy, surgical	8.84	NA	4.56	0.58	000
31287		A	Nasal/sinus endoscopy, surg	3.91	NA	2.24	0.26	000
31288		A	Nasal/sinus endoscopy, surg	4.57	NA	2.56	0.30	000
31290		A	Nasal/sinus endoscopy, surg	18.50	NA	11.68	1.44	010
31291		A	Nasal/sinus endoscopy, surg	19.45	NA	12.19	1.76	010
31292		A	Nasal/sinus endoscopy, surg	15.79	NA	10.37	1.04	010
31293		A	Nasal/sinus endoscopy, surg	17.36	NA	11.12	1.13	010
31294		A	Nasal/sinus endoscopy, surg	20.20	NA	12.45	1.31	010
31299		C	Sinus surgery procedure	0.00	0.00	0.00	0.00	YYY
31300		A	Removal of larynx lesion	15.71	NA	16.99	1.53	090
31320		A	Diagnostic incision, larynx	5.62	NA	11.01	0.55	090
31360		A	Removal of larynx	29.57	NA	24.24	2.94	090
31365		A	Removal of larynx	38.47	NA	28.45	3.83	090
31367		A	Partial removal of larynx	30.23	NA	26.77	2.98	090
31368		A	Partial removal of larynx	33.85	NA	29.46	3.30	090
31370		A	Partial removal of larynx	27.23	NA	26.21	2.66	090
31375		A	Partial removal of larynx	25.73	NA	24.96	2.51	090
31380		A	Partial removal of larynx	25.23	NA	24.72	2.46	090
31382		A	Partial removal of larynx	28.23	NA	26.68	2.75	090
31390		A	Removal of larynx & pharynx	42.17	NA	31.39	4.41	090
31395		A	Reconstruct larynx & pharynx	43.46	NA	34.73	4.24	090
31400		A	Revision of larynx	11.48	NA	14.15	1.12	090
31420		A	Removal of epiglottis	11.32	NA	10.31	1.10	090
31500		A	Insert emergency airway	2.33	NA	0.51	0.19	000
31502		A	Change of windpipe airway	0.65	NA	0.28	0.05	000
31505		A	Diagnostic laryngoscopy	0.61	1.51	0.67	0.04	000
31510		A	Laryngoscopy with biopsy	1.92	3.47	1.26	0.14	000
31511		A	Remove foreign body, larynx	2.16	3.24	1.23	0.17	000
31512		A	Removal of larynx lesion	2.07	3.28	1.38	0.13	000
31513		A	Injection into vocal cord	2.10	NA	1.39	0.14	000
31515		A	Laryngoscopy for aspiration	1.80	3.50	1.09	0.14	000
31520		A	Dx laryngoscopy, newborn	2.56	NA	1.61	0.17	000
31525		A	Dx laryngoscopy excl nb	2.63	3.81	1.58	0.18	000
31526		A	Dx laryngoscopy w/oper scope	2.57	NA	1.61	0.17	000
31527		A	Laryngoscopy for treatment	3.27	NA	1.95	0.21	000
31528		A	Laryngoscopy and dilation	2.37	NA	1.47	0.16	000
31529		A	Laryngoscopy and dilation	2.68	NA	1.60	0.18	000
31530		A	Laryngoscopy w/fb removal	3.38	NA	1.86	0.24	000
31531		A	Laryngoscopy w/fb & op scope	3.58	NA	2.08	0.23	000
31535		A	Laryngoscopy w/biopsy	3.16	NA	1.88	0.21	000
31536		A	Laryngoscopy w/bx & op scope	3.55	NA	2.08	0.23	000
31540		A	Laryngoscopy w/exc of tumor	4.12	NA	2.33	0.27	000
31541		A	Laryngoscop w/tumr exc + scope	4.52	NA	2.53	0.30	000
31545		A	Remove vc lesion w/scope	6.30	NA	3.39	0.41	000
31546		A	Remove vc lesion scope/graft	9.73	NA	5.02	0.63	000
31560		A	Laryngoscop w/arytenoidectom	5.45	NA	2.93	0.35	000
31561		A	Laryngoscop, remve cart + scop	5.99	NA	3.16	0.40	000
31570		A	Laryngoscope w/vc inj	3.86	4.79	2.16	0.26	000

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
31571		A	Laryngoscop w/vc inj + scope	4.26	NA	2.41	0.28	000
31575		A	Diagnostic laryngoscopy	1.10	1.85	0.91	0.07	000
31576		A	Laryngoscopy with biopsy	1.97	3.77	1.30	0.13	000
31577		A	Remove foreign body, larynx	2.47	3.75	1.48	0.17	000
31578		A	Removal of larynx lesion	2.84	4.38	1.74	0.18	000
31579		A	Diagnostic laryngoscopy	2.26	3.19	1.47	0.15	000
31580		A	Revision of larynx	14.46	NA	16.93	1.41	090
31582		A	Revision of larynx	22.87	NA	25.79	2.23	090
31584		A	Treat larynx fracture	20.35	NA	18.83	1.98	090
31587		A	Revision of larynx	15.12	NA	11.00	1.47	090
31588		A	Revision of larynx	14.62	NA	14.58	1.43	090
31590		A	Reinnervate larynx	7.63	NA	14.84	0.74	090
31595		A	Larynx nerve surgery	8.75	NA	10.89	0.85	090
31599		C	Larynx surgery procedure	0.00	0.00	0.00	0.00	YYY
31600		A	Incision of windpipe	7.17	NA	3.04	0.87	000
31601		A	Incision of windpipe	4.44	NA	2.46	0.29	000
31603		A	Incision of windpipe	4.14	NA	1.64	0.46	000
31605		A	Incision of windpipe	3.57	NA	1.09	0.42	000
31610		A	Incision of windpipe	9.29	NA	9.06	0.98	090
31611		A	Surgery/speech prosthesis	5.92	NA	7.91	0.58	090
31612		A	Puncture/clear windpipe	0.91	1.18	0.35	0.08	000
31613		A	Repair windpipe opening	4.63	NA	6.87	0.54	090
31614		A	Repair windpipe opening	8.47	NA	10.79	0.87	090
31615		A	Visualization of windpipe	2.09	2.58	1.28	0.14	000
31620		A	Endobronchial us add-on	1.40	5.32	0.40	0.10	ZZZ
31622		A	Dx bronchoscope/wash	2.78	4.96	1.04	0.24	000
31623		A	Dx bronchoscope/brush	2.88	5.36	1.02	0.19	000
31624		A	Dx bronchoscope/lavage	2.88	4.89	1.04	0.19	000
31625		A	Bronchoscopy w/biopsy(s)	3.36	5.04	1.18	0.24	000
31628		A	Bronchoscopy/lung bx, each	3.80	6.21	1.28	0.23	000
31629		A	Bronchoscopy/needle bx, each	4.09	10.54	1.37	0.26	000
31630		A	Bronchoscopy dilate/fx repr	3.81	NA	1.46	0.35	000
31631		A	Bronchoscopy, dilate w/stent	4.36	NA	1.65	0.41	000
31632		A	Bronchoscopy/lung bx, addÆ1	1.03	0.82	0.30	0.06	ZZZ
31633		A	Bronchoscopy/needle bx addÆ1	1.32	0.95	0.38	0.08	ZZZ
31635		A	Bronchoscopy w/fb removal	3.67	4.92	1.30	0.29	000
31636		A	Bronchoscopy, bronch stents	4.30	NA	1.51	0.41	000
31637		A	Bronchoscopy, stent add-on	1.58	NA	0.42	0.09	ZZZ
31638		A	Bronchoscopy, revise stent	4.88	NA	1.77	0.46	000
31640		A	Bronchoscopy w/tumor excise	4.93	NA	1.80	0.44	000
31641		A	Bronchoscopy, treat blockage	5.02	NA	1.78	0.41	000
31643		A	Diag bronchoscope/catheter	3.49	NA	1.15	0.22	000

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31645		A	Bronchoscopy, clear airways	3.16	4.40	1.12	0.21	000
31646		A	Bronchoscopy, reclear airway	2.72	4.11	0.98	0.19	000
31656		A	Bronchoscopy, inj for x-ray	2.17	5.17	0.76	0.12	000
31715		A	Injection for bronchus x-ray	1.11	NA	0.30	0.06	000
31717		A	Bronchial brush biopsy	2.12	4.22	0.74	0.15	000
31720		A	Clearance of airways	1.06	NA	0.31	0.06	000
31725		A	Clearance of airways	1.96	NA	0.55	0.15	000
31730		A	Intro, windpipe wire/tube	2.85	26.35	0.99	0.32	000
31750		A	Repair of windpipe	15.19	NA	19.54	1.70	090
31755		A	Repair of windpipe	17.19	NA	26.75	1.68	090
31760		A	Repair of windpipe	23.36	NA	10.74	4.15	090
31766		A	Reconstruction of windpipe	31.58	NA	15.08	5.61	090
31770		A	Repair/graft of bronchus	23.48	NA	9.71	4.17	090
31775		A	Reconstruct bronchus	24.51	NA	10.32	4.36	090
31780		A	Reconstruct windpipe	19.70	NA	10.99	2.38	090
31781		A	Reconstruct windpipe	24.77	NA	13.67	2.42	090
31785		A	Remove windpipe lesion	18.29	NA	10.01	1.97	090
31786		A	Remove windpipe lesion	25.34	NA	10.57	4.50	090
31800		A	Repair of windpipe injury	8.10	NA	10.25	0.79	090
31805		A	Repair of windpipe injury	13.34	NA	8.05	2.37	090
31820		A	Closure of windpipe lesion	4.58	6.54	3.89	0.49	090
31825		A	Repair of windpipe defect	6.98	8.45	5.44	0.72	090
31830		A	Revise windpipe scar	4.54	6.57	4.14	0.52	090
31899		C	Airways surgical procedure	0.00	0.00	0.00	0.00	YYY
32035		A	Exploration of chest	11.20	NA	6.86	1.95	090
32036		A	Exploration of chest	12.21	NA	7.22	2.16	090
32095		A	Biopsy through chest wall	10.06	NA	5.82	1.78	090
32100		A	Exploration/biopsy of chest	16.08	NA	7.90	2.86	090
32110		A	Explore/repair chest	25.15	NA	11.48	4.23	090
32120		A	Re-exploration of chest	14.27	NA	7.59	2.55	090
32124		A	Explore chest free adhesions	15.33	NA	8.00	2.76	090
32140		A	Removal of lung lesion(s)	16.54	NA	8.50	3.14	090
32141		A	Remove/treat lung lesions	27.10	NA	11.54	4.85	090
32150		A	Removal of lung lesion(s)	16.70	NA	8.47	2.97	090
32151		A	Remove lung foreign body	16.82	NA	8.19	2.99	090
32160		A	Open chest heart massage	13.02	NA	6.66	2.26	090
32200		A	Drain, open, lung lesion	18.48	NA	9.98	3.28	090
32201		A	Drain, percut, lung lesion	3.99	14.43	1.21	0.29	000
32215		A	Treat chest lining	12.93	NA	7.17	2.27	090
32220		A	Release of lung	26.41	NA	13.43	4.74	090
32225		A	Partial release of lung	16.63	NA	8.38	2.96	090
32310		A	Removal of chest lining	15.16	NA	7.92	2.73	090

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
32320		A	Free/remove chest lining	27.04	NA	13.13	4.77	090
32400		A	Needle biopsy chest lining	1.76	1.96	0.53	0.13	000
32402		A	Open biopsy chest lining	8.89	NA	5.37	1.53	090
32405		A	Biopsy, lung or mediastinum	1.93	0.58	0.58	0.14	000
32420		A	Puncture/clear lung	2.18	NA	0.66	0.17	000
32421		A	Thoracentesis for aspiration	1.54	2.26	0.48	0.11	000
32422		A	Thoracentesis w/tube insert	2.19	2.70	1.01	0.16	000
32440		A	Removal of lung	27.17	NA	12.34	4.81	090
32442		A	Sleeve pneumonectomy	56.37	NA	19.00	3.21	090
32445		A	Removal of lung	63.60	NA	24.43	11.30	090
32480		A	Partial removal of lung	25.71	NA	11.62	4.58	090
32482		A	Bilobectomy	27.28	NA	12.63	4.86	090
32484		A	Segmentectomy	25.30	NA	10.94	4.48	090
32486		A	Sleeve lobectomy	42.80	NA	16.45	7.69	090
32488		A	Completion pneumonectomy	42.83	NA	17.34	7.66	090
32491		R	Lung volume reduction	25.09	NA	11.63	4.46	090
32500		A	Partial removal of lung	24.48	NA	11.65	4.38	090
32501		A	Repair bronchus add-on	4.68	NA	1.50	0.82	ZZZ
32503		A	Resect apical lung tumor	31.61	NA	13.53	5.64	090
32504		A	Resect apical lung tum/chest	36.41	NA	15.16	6.39	090
32540		A	Removal of lung lesion	30.22	NA	13.30	5.39	090
32550		A	Insert pleural cath	4.17	15.32	1.58	0.52	000
32551		A	Insertion of chest tube	3.29	NA	1.10	0.38	000
32560		A	Treat lung lining chemically	2.19	5.21	0.69	0.28	000
32601		A	Thoracoscopy, diagnostic	5.45	NA	2.31	0.94	000
32602		A	Thoracoscopy, diagnostic	5.95	NA	2.48	1.02	000
32603		A	Thoracoscopy, diagnostic	7.80	NA	3.03	1.48	000
32604		A	Thoracoscopy, diagnostic	8.77	NA	3.27	1.56	000
32605		A	Thoracoscopy, diagnostic	6.92	NA	2.71	1.23	000
32606		A	Thoracoscopy, diagnostic	8.39	NA	3.29	1.45	000
32650		A	Thoracoscopy, surgical	10.77	NA	6.01	1.88	090
32651		A	Thoracoscopy, surgical	18.70	NA	8.86	3.25	090
32652		A	Thoracoscopy, surgical	29.00	NA	12.71	5.10	090
32653		A	Thoracoscopy, surgical	18.09	NA	8.43	3.14	090
32654		A	Thoracoscopy, surgical	20.44	NA	9.29	3.52	090
32655		A	Thoracoscopy, surgical	16.09	NA	8.02	2.83	090
32656		A	Thoracoscopy, surgical	13.18	NA	6.89	2.28	090
32657		A	Thoracoscopy, surgical	12.85	NA	6.86	2.28	090
32658		A	Thoracoscopy, surgical	11.65	NA	6.11	2.07	090
32659		A	Thoracoscopy, surgical	11.86	NA	6.42	2.12	090
32660		A	Thoracoscopy, surgical	17.69	NA	8.12	3.36	090
32661		A	Thoracoscopy, surgical	13.27	NA	6.60	2.36	090
32662		A	Thoracoscopy, surgical	14.91	NA	7.57	2.63	090
32663		A	Thoracoscopy, surgical	24.56	NA	10.56	4.35	090
32664		A	Thoracoscopy, surgical	14.22	NA	6.89	2.53	090
32665		A	Thoracoscopy, surgical	21.45	NA	10.93	3.47	090
32800		A	Repair lung hernia	15.59	NA	6.32	0.89	090
32810		A	Close chest after drainage	14.83	NA	7.55	2.64	090
32815		A	Close bronchial fistula	49.79	NA	20.68	8.99	090
32820		A	Reconstruct injured chest	22.33	NA	10.69	3.97	090
32851		A	Lung transplant, single	40.94	NA	22.74	7.33	090
32852		A	Lung transplant with bypass	44.65	NA	25.63	7.93	090
32853		A	Lung transplant, double	50.11	NA	25.66	9.01	090
32854		A	Lung transplant with bypass	53.88	NA	29.20	9.63	090
32855		C	Prepare donor lung, single	0.00	0.00	0.00	0.00	XXX
32856		C	Prepare donor lung, double	0.00	0.00	0.00	0.00	XXX
32900		A	Removal of rib(s)	23.69	NA	11.00	4.16	090
32905		A	Revise & repair chest wall	23.17	NA	10.09	4.12	090
32906		A	Revise & repair chest wall	29.18	NA	11.92	5.19	090
32940		A	Revision of lung	21.22	NA	9.50	3.77	090
32960		A	Therapeutic pneumothorax	1.84	1.89	0.74	0.33	000
32997		A	Total lung lavage	7.31	NA	2.12	0.73	000
32998		A	Perq rf ablate tx, pul tumor	5.68	60.11	1.83	0.46	000
32999		C	Chest surgery procedure	0.00	0.00	0.00	0.00	YYY
33010		A	Drainage of heart sac	2.24	NA	0.72	0.18	000
33011		A	Repeat drainage of heart sac	2.24	NA	0.75	0.16	000
33015		A	Incision of heart sac	8.44	NA	4.14	1.26	090
33020		A	Incision of heart sac	14.87	NA	7.18	2.65	090
33025		A	Incision of heart sac	13.65	NA	6.54	2.47	090
33030		A	Partial removal of heart sac	22.27	NA	10.15	4.02	090
33031		A	Partial removal of heart sac	25.30	NA	10.73	4.63	090
33050		A	Removal of heart sac lesion	16.85	NA	8.32	2.99	090
33120		A	Removal of heart lesion	27.33	NA	11.89	4.96	090
33130		A	Removal of heart lesion	24.05	NA	17.56	4.57	090
33140		A	Heart revascularize (tmr)	28.26	NA	11.32	5.37	090
33141		A	Heart tmr w/other procedure	2.54	NA	0.83	0.46	ZZZ
33202		A	Insert epicard eltrd, open	13.15	NA	6.25	2.38	090
33203		A	Insert epicard eltrd, endo	13.92	NA	6.14	2.43	090
33206		A	Insertion of heart pacemaker	7.31	NA	3.78	1.19	090
33207		A	Insertion of heart pacemaker	8.00	NA	3.81	1.31	090
33208		A	Insertion of heart pacemaker	8.72	NA	4.04	1.42	090
33210		A	Insertion of heart electrode	3.30	NA	1.10	0.25	000
33211		A	Insertion of heart electrode	3.39	NA	1.11	0.36	000
33212		A	Insertion of pulse generator	5.51	NA	2.75	0.90	090

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CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
33213		A	Insertion of pulse generator	6.36	NA	3.02	1.04	090
33214		A	Upgrade of pacemaker system	7.78	NA	3.96	1.25	090
33215		A	Reposition pacing-defib lead	4.89	NA	2.50	0.80	090
33216		A	Insert lead pace-defib, one	5.81	NA	3.25	0.94	090
33217		A	Insert lead pace-defib, dual	5.78	NA	3.25	0.95	090
33218		A	Repair lead pace-defib, one	5.97	NA	3.44	0.98	090
33218F		I	AJCC cncr 0/1A melan docd	0.00	0.00	0.00	0.00	XXX
33220		A	Repair lead pace-defib, dual	6.05	NA	3.50	0.98	090
33222		A	Revise pocket, pacemaker	5.01	NA	3.34	0.83	090
33223		A	Revise pocket, pacing-defib	6.49	NA	3.48	1.07	090
33224		A	Insert pacing lead & connect	9.04	NA	3.35	0.81	000
33225		A	L ventric pacing lead add-on	8.33	NA	2.80	0.63	ZZZ
33226		A	Reposition l ventric lead	8.68	NA	3.23	0.78	000
3322F		I	Melan >AJCC stage 0 or IA	0.00	0.00	0.00	0.00	XXX
33233		A	Removal of pacemaker system	3.33	NA	2.36	0.54	090
33234		A	Removal of pacemaker system	7.85	NA	3.94	1.28	090
33235		A	Removal pacemaker electrode	9.93	NA	5.28	1.64	090
33236		A	Remove electrode/thoracotomy	12.64	NA	7.05	2.40	090
33237		A	Remove electrode/thoracotomy	13.75	NA	6.56	2.44	090
33238		A	Remove electrode/thoracotomy	15.28	NA	8.23	2.75	090
33240		A	Insert pulse generator	7.61	NA	3.56	1.23	090
33241		A	Remove pulse generator	3.26	NA	2.11	0.53	090
33243		A	Remove elrd/thoracotomy	23.42	NA	10.79	4.19	090
33244		A	Remove elrd, transven	13.84	NA	6.73	2.28	090
33249		A	Elrd/insert pace-defib	15.02	NA	6.81	2.42	090
33250		A	Ablate heart dysrhythm focus	25.78	NA	11.09	4.90	090
33251		A	Ablate heart dysrhythm focus	28.80	NA	12.77	5.30	090
33254		A	Ablate atria, lmtd	23.58	NA	10.89	4.48	090
33255		A	Ablate atria w/o bypass, ext	28.91	NA	12.47	5.49	090
33256		A	Ablate atria w/bypass, exten	34.77	NA	14.36	6.61	090
33257		A	Ablate atria, lmtd, add-on	9.63	NA	5.25	1.74	ZZZ
33258		A	Ablate atria, x10sv, add-on	11.00	NA	5.74	1.97	ZZZ
33259		A	Ablate atria w/bypass add-on	14.14	NA	7.44	2.56	ZZZ
33261		A	Ablate heart dysrhythm focus	28.80	NA	12.03	5.47	090
33265		A	Ablate atria, lmtd, endo	23.58	NA	10.76	4.26	090
33266		A	Ablate atria, x10sv, endo	32.91	NA	13.78	6.01	090
33282		A	Implant pat-active ht record	4.70	NA	2.96	0.76	090
33284		A	Remove pat-active ht record	3.04	NA	2.41	0.49	090
33300		A	Repair of heart wound	44.89	NA	16.98	8.12	090
33305		A	Repair of heart wound	76.85	NA	27.04	13.95	090
33310		A	Exploratory heart surgery	20.22	NA	9.40	3.59	090
33315		A	Exploratory heart surgery	26.05	NA	11.36	4.76	090
33320		A	Repair major blood vessel(s)	18.46	NA	8.26	3.22	090
33321		A	Repair major vessel	20.71	NA	9.87	1.11	090
33322		A	Repair major blood vessel(s)	24.30	NA	10.97	4.44	090
33330		A	Insert major vessel graft	25.17	NA	12.64	4.78	090
33332		A	Insert major vessel graft	24.46	NA	10.53	4.65	090
33335		A	Insert major vessel graft	33.79	NA	14.24	6.20	090
33400		A	Repair of aortic valve	41.37	NA	16.42	7.44	090
33401		A	Valvuloplasty, open	24.41	NA	10.64	4.05	090
33403		A	Valvuloplasty, w/cp bypass	25.39	NA	11.83	4.82	090
33404		A	Prepare heart-aorta conduit	31.25	NA	13.24	5.55	090
33405		A	Replacement of aortic valve	41.19	NA	16.90	7.51	090
33406		A	Replacement of aortic valve	52.55	NA	20.51	9.68	090
33410		A	Replacement of aortic valve	46.28	NA	18.36	8.45	090
33411		A	Replacement of aortic valve	61.94	NA	23.64	11.31	090
33412		A	Replacement of aortic valve	43.77	NA	18.03	8.31	090
33413		A	Replacement of aortic valve	59.74	NA	21.70	10.62	090
33414		A	Repair of aortic valve	39.29	NA	15.14	6.98	090
33415		A	Revision, subvalvular tissue	37.19	NA	14.74	6.02	090
33416		A	Revise ventricle muscle	36.43	NA	15.36	6.65	090
33417		A	Repair of aortic valve	29.17	NA	13.10	5.32	090
33420		A	Revision of mitral valve	25.67	NA	11.89	2.59	090
33422		A	Revision of mitral valve	29.61	NA	12.57	5.62	090
33425		A	Repair of mitral valve	49.83	NA	19.43	9.10	090
33426		A	Repair of mitral valve	43.15	NA	17.61	7.85	090
33427		A	Repair of mitral valve	44.70	NA	17.48	8.13	090
33430		A	Replacement of mitral valve	50.75	NA	20.68	9.28	090
33460		A	Revision of tricuspid valve	44.62	NA	29.10	8.48	090
33463		A	Valvuloplasty, tricuspid	56.95	NA	21.67	10.45	090
33464		A	Valvuloplasty, tricuspid	44.49	NA	18.08	8.02	090
33465		A	Replace tricuspid valve	50.59	NA	19.57	9.29	090
33468		A	Revision of tricuspid valve	32.82	NA	13.32	6.23	090
33470		A	Revision of pulmonary valve	21.32	NA	9.42	3.79	090
33471		A	Valvotomy, pulmonary valve	22.83	NA	10.92	1.22	090
33472		A	Revision of pulmonary valve	22.90	NA	10.45	1.23	090
33474		A	Revision of pulmonary valve	39.27	NA	15.16	7.46	090
33475		A	Replacement, pulmonary valve	42.27	NA	16.42	8.03	090
33476		A	Revision of heart chamber	26.41	NA	11.76	5.02	090
33478		A	Revision of heart chamber	27.38	NA	12.06	5.20	090
33496		A	Repair, prosth valve clot	29.71	NA	12.97	5.28	090
33500		A	Repair heart vessel fistula	27.82	NA	11.72	5.28	090
33501		A	Repair heart vessel fistula	19.43	NA	8.85	3.69	090
33502		A	Coronary artery correction	21.69	NA	10.29	4.12	090

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CPT[1,7] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,4]	Global
33503		A	Coronary artery graft	22.29	NA	9.94	3.70	090
33504		A	Coronary artery graft	25.30	NA	11.45	4.81	090
33505		A	Repair artery w/tunnel	38.35	NA	13.30	7.29	090
33506		A	Repair artery, translocation	37.80	NA	13.64	6.72	090
33507		A	Repair art, intramural	31.35	NA	11.81	5.57	090
33508		A	Endoscopic vein harvest	0.31	NA	0.10	0.06	ZZZ
33510		A	CABG, vein, single	34.87	NA	14.65	6.36	090
33511		A	CABG, vein, two	38.34	NA	15.95	7.01	090
33512		A	CABG, vein, three	43.87	NA	17.66	8.02	090
33513		A	CABG, vein, four	45.26	NA	18.04	8.30	090
33514		A	CABG, vein, five	47.97	NA	18.97	8.75	090
33516		A	Cabg, vein, six or more	49.65	NA	19.03	9.43	090
33517		A	CABG, artery-vein, single	3.61	NA	1.18	0.64	ZZZ
33518		A	CABG, artery-vein, two	7.93	NA	2.60	1.42	ZZZ
33519		A	CABG, artery-vein, three	10.49	NA	3.44	1.88	ZZZ
3351F		I	Neg scrn dep symp by deptool	0.00	0.00	0.00	0.00	XXX
33521		A	CABG, artery-vein, four	12.59	NA	4.14	2.25	ZZZ
33522		A	CABG, artery-vein, five	14.14	NA	4.66	2.53	ZZZ
33523		A	Cabg, art-vein, six or more	16.08	NA	5.24	2.88	ZZZ
3352F		I	No sig dep symp by dep tool	0.00	0.00	0.00	0.00	XXX
33530		A	Coronary artery, bypass/reop	10.13	NA	3.29	1.82	ZZZ
33533		A	CABG, arterial, single	33.64	NA	14.05	6.15	090
33534		A	CABG, arterial, two	39.77	NA	16.38	7.26	090
33535		A	CABG, arterial, three	44.64	NA	17.96	8.14	090
33536		A	Cabg, arterial, four or more	48.32	NA	19.38	8.86	090
3353F		I	Mild-mod dep symp by deptool	0.00	0.00	0.00	0.00	XXX
33542		A	Removal of heart lesion	48.08	NA	18.78	8.82	090
33545		A	Repair of heart damage	56.93	NA	21.28	10.37	090
33548		A	Restore/remodel, ventricle	53.96	NA	21.50	9.87	090
3354F		I	Clin sig dep sym by dep tool	0.00	0.00	0.00	0.00	XXX
33572		A	Open coronary endarterectomy	4.44	NA	1.44	0.80	ZZZ
33600		A	Closure of valve	30.15	NA	12.73	5.36	090
33602		A	Closure of valve	29.18	NA	14.68	4.73	090
33606		A	Anastomosis/artery-aorta	31.37	NA	15.38	5.08	090
33608		A	Repair anomaly w/conduit	31.72	NA	13.21	5.64	090
33610		A	Repair by enlargement	31.24	NA	13.06	5.55	090
33611		A	Repair double ventricle	35.49	NA	13.61	6.74	090
33612		A	Repair double ventricle	36.49	NA	13.81	6.06	090
33615		A	Repair, modified fontan	35.76	NA	14.13	6.35	090
33617		A	Repair single ventricle	38.96	NA	15.11	6.92	090
33619		A	Repair single ventricle	48.60	NA	19.55	8.64	090
33641		A	Repair heart septum defect	29.50	NA	12.39	5.35	090
33645		A	Revision of heart veins	27.98	NA	11.60	5.32	090
33647		A	Repair heart septum defects	29.37	NA	21.27	5.58	090
33660		A	Repair of heart defects	31.75	NA	12.45	6.03	090
33665		A	Repair of heart defects	34.77	NA	23.33	6.61	090
33670		A	Repair of heart chambers	36.58	NA	13.09	6.95	090
33675		A	Close mult vsd	35.87	NA	13.51	6.37	090
33676		A	Close mult vsd w/resection	36.87	NA	15.51	1.97	090
33677		A	Cl mult vsd w/rem pul band	38.37	NA	16.06	2.05	090
33681		A	Repair heart septum defect	32.16	NA	14.49	5.89	090
33684		A	Repair heart septum defect	34.29	NA	22.75	6.51	090
33688		A	Repair heart septum defect	34.67	NA	12.73	6.59	090
33690		A	Reinforce pulmonary artery	20.20	NA	9.69	3.59	090
33692		A	Repair of heart defects	31.38	NA	13.58	1.68	090
33694		A	Repair of heart defects	35.49	NA	13.36	6.74	090
33697		A	Repair of heart defects	37.49	NA	14.14	6.22	090
33702		A	Repair of heart defects	27.11	NA	11.70	5.15	090
33710		A	Repair of heart defects	30.28	NA	12.46	5.38	090
33720		A	Repair of heart defect	27.13	NA	11.50	4.82	090
33722		A	Repair of heart defect	29.05	NA	11.51	5.52	090
33724		A	Repair venous anomaly	27.55	NA	10.97	4.90	090
33726		A	Repair pul venous stenosis	37.04	NA	14.13	7.04	090
33730		A	Repair heart-vein defect(s)	36.01	NA	14.37	6.84	090
33732		A	Repair heart-vein defect	28.80	NA	12.54	5.47	090
33735		A	Revision of heart chamber	22.04	NA	10.26	4.19	090
33736		A	Revision of heart chamber	24.16	NA	11.10	4.59	090
33737		A	Revision of heart chamber	22.34	NA	10.04	3.97	090
33750		A	Major vessel shunt	22.06	NA	14.81	6.00	090
33755		A	Major vessel shunt	22.44	NA	9.76	3.72	090
33762		A	Major vessel shunt	22.44	NA	10.32	1.20	090
33764		A	Major vessel shunt & graft	22.44	NA	12.18	3.63	090
33766		A	Major vessel shunt	23.41	NA	9.51	3.89	090
33767		A	Major vessel shunt	25.14	NA	10.32	4.47	090
33768		A	Cavopulmonary shunting	8.00	NA	2.92	0.43	ZZZ
33770		A	Repair great vessels defect	39.02	NA	16.60	6.93	090
33771		A	Repair great vessels defect	40.58	NA	16.10	2.17	090
33774		A	Repair great vessels defect	31.54	NA	13.58	5.99	090
33775		A	Repair great vessels defect	32.83	NA	14.73	1.76	090
33776		A	Repair great vessels defect	34.53	NA	15.64	1.85	090
33777		A	Repair great vessels defect	33.95	NA	14.67	1.82	090
33778		A	Repair great vessels defect	42.62	NA	18.05	2.28	090
33779		A	Repair great vessels defect	43.15	NA	15.07	7.67	090
33780		A	Repair great vessels defect	43.85	NA	28.22	2.35	090

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CPT[1,2]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
33781		A	Repair great vessels defect	43.16	NA	17.04	2.31	090
33786		A	Repair arterial trunk	41.74	NA	17.18	2.24	090
33788		A	Revision of pulmonary artery	27.26	NA	12.07	1.46	090
33800		A	Aortic suspension	17.23	NA	7.61	3.27	090
33802		A	Repair vessel defect	18.24	NA	8.79	3.46	090
33803		A	Repair vessel defect	20.18	NA	8.50	3.83	090
33813		A	Repair septal defect	21.23	NA	9.70	3.77	090
33814		A	Repair septal defect	26.41	NA	11.80	5.02	090
33820		A	Revise major vessel	16.61	NA	7.73	3.16	090
33822		A	Revise major vessel	17.63	NA	8.46	0.94	090
33824		A	Revise major vessel	20.10	NA	10.36	3.57	090
33840		A	Remove aorta constriction	21.21	NA	9.15	4.03	090
33845		A	Remove aorta constriction	22.77	NA	10.67	4.33	090
33851		A	Remove aorta constriction	21.85	NA	9.89	4.15	090
33852		A	Repair septal defect	24.28	NA	17.93	4.61	090
33853		A	Repair septal defect	32.35	NA	23.03	6.15	090
33860		A	Ascending aortic graft	59.33	NA	22.27	10.78	090
33861		A	Ascending aortic graft	43.94	NA	17.46	8.04	090
33863		A	Ascending aortic graft	58.71	NA	21.32	10.75	090
33864		A	Ascending aortic graft	60.00	NA	21.94	10.89	090
33870		A	Transverse aortic arch graft	45.93	NA	17.91	8.31	090
33875		A	Thoracic aortic graft	35.68	NA	14.00	6.47	090
33877		A	Thoracoabdominal graft	68.85	NA	23.54	12.40	090
33880		A	Endovasc taa repr incl subcl	34.48	NA	12.17	5.86	090
33881		A	Endovasc taa repr w/o subcl	29.48	NA	10.56	5.01	090
33883		A	Insert endovasc prosth, taa	20.99	NA	8.05	3.55	090
33884		A	Endovasc prosth, taa, add-on	8.20	NA	2.44	1.34	ZZZ
33886		A	Endovasc prosth, delayed	17.99	NA	6.43	3.24	090
33889		A	Artery transpose/endovas taa	15.92	NA	4.32	2.87	000
33891		A	Car-car bp grft/endovas taa	20.00	NA	5.43	3.61	000
33910		A	Remove lung artery emboli	29.59	NA	12.66	5.62	090
33915		A	Remove lung artery emboli	24.83	NA	11.69	4.12	090
33916		A	Surgery of great vessel	28.30	NA	11.66	5.38	090
33917		A	Repair pulmonary artery	25.14	NA	11.40	4.47	090
33920		A	Repair pulmonary atresia	32.58	NA	12.59	6.19	090
33922		A	Transect pulmonary artery	24.09	NA	10.76	4.58	090
33924		A	Remove pulmonary shunt	5.49	NA	1.68	0.98	ZZZ
33925		A	Rpr pul art unifocal w/o cpb	31.25	NA	11.78	5.55	090
33926		A	Repr pul art, unifocal w/cpb	44.68	NA	19.03	8.49	090
33933		C	Prepare donor heart/lung	0.00	0.00	0.00	0.00	XXX
33935		R	Transplantation, heart/lung	61.68	NA	24.94	11.72	090
33944		C	Prepare donor heart	0.00	0.00	0.00	0.00	XXX
33945		R	Transplantation of heart	89.08	NA	33.06	16.09	090
33960		A	External circulation assist	19.33	NA	5.90	3.67	000
33961		A	External circulation assist	10.91	NA	3.32	1.12	ZZZ
33967		A	Insert ia percut device	4.84	NA	1.61	0.44	000
33968		A	Remove aortic assist device	0.64	NA	0.23	0.08	000
33970		A	Aortic circulation assist	6.74	NA	2.20	0.97	000
33971		A	Aortic circulation assist	11.91	NA	5.95	2.10	090
33973		A	Insert balloon device	9.75	NA	3.15	1.40	000
33974		A	Remove intra-aortic balloon	14.93	NA	6.83	2.84	090
33975		A	Implant ventricular device	20.97	NA	6.78	3.45	XXX
33976		A	Implant ventricular device	22.97	NA	7.15	4.36	XXX
33977		A	Remove ventricular device	20.07	NA	10.39	3.60	090
33978		A	Remove ventricular device	22.51	NA	11.12	4.00	090
33979		A	Insert intracorporeal device	45.93	NA	14.44	8.21	XXX
33980		A	Remove intracorporeal device	64.86	NA	26.41	11.92	090
33999		C	Cardiac surgery procedure	0.00	0.00	0.00	0.00	YYY
34001		A	Removal of artery clot	17.78	NA	7.71	3.09	090
34051		A	Removal of artery clot	16.91	NA	8.14	3.21	090
34101		A	Removal of artery clot	10.85	NA	5.07	1.87	090
34111		A	Removal of arm artery clot	10.85	NA	5.10	1.85	090
34151		A	Removal of artery clot	26.41	NA	10.48	4.49	090
34201		A	Removal of artery clot	19.38	NA	7.83	3.38	090
34203		A	Removal of leg artery clot	17.73	NA	7.51	3.09	090
34401		A	Removal of vein clot	26.41	NA	10.98	4.28	090
34421		A	Removal of vein clot	13.29	NA	6.03	2.21	090
34451		A	Removal of vein clot	28.41	NA	9.38	5.12	090
34471		A	Removal of vein clot	21.00	NA	10.45	3.40	090
34490		A	Removal of vein clot	10.83	NA	5.20	1.84	090
34501		A	Repair valve, femoral vein	16.74	NA	6.78	3.02	090
34502		A	Reconstruct vena cava	27.86	NA	11.55	4.40	090
3450F		I	Dyspnea scrnd, no-mild dysp	0.00	0.00	0.00	0.00	XXX
34510		A	Transposition of vein valve	19.80	NA	10.03	3.21	090
3451F		I	Dyspnea scrnd mod-high dysp	0.00	0.00	0.00	0.00	XXX
34520		A	Cross-over vein graft	19.05	NA	6.94	3.44	090
3452F		I	Dyspnea not screened	0.00	0.00	0.00	0.00	XXX
34530		A	Leg vein fusion	17.77	NA	9.85	2.88	090
34800		A	Endovas aaa repr w/sm tube	21.46	NA	8.03	3.47	090
34802		A	Endovas aaa repr w/2-p part	23.71	NA	8.97	3.86	090
34803		A	Endovas aaa repr w/3-p part	24.74	NA	9.06	4.04	090
34804		A	Endovas aaa repr w/1-p part	23.71	NA	8.99	3.92	090
34805		A	Endovas aaa repr w/long tube	22.59	NA	8.37	3.80	090
34806		A	Aneurysm press sensor add-on	2.06	NA	0.61	0.34	ZZZ

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CPT[1,2]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
34808		A	Endovas iliac a device addon	4.12	NA	1.22	0.69	ZZZ
34812		A	Xpose for endoprosth, femorl	6.74	NA	2.09	1.17	000
34813		A	Femoral endovas graft add-on	4.79	NA	1.43	0.83	ZZZ
34820		A	Xpose for endoprosth, iliac	9.74	NA	2.93	1.64	000
34825		A	Endovasc extend prosth, init	12.72	NA	5.56	2.08	090
34826		A	Endovasc exten prosth, add/E1	4.12	NA	1.28	0.65	ZZZ
34830		A	Open aortic tube prosth repr	35.10	NA	11.28	6.33	090
34831		A	Open aortoiliac prosth repr	37.85	NA	12.03	6.83	090
34832		A	Open aortofemor prosth repr	37.85	NA	12.03	6.83	090
34833		A	Xpose for endoprosth, iliac	11.98	NA	3.89	2.09	000
34834		A	Endovasc iliac repr w/graft	5.34	NA	1.82	0.94	000
34900		A	Xpose, endoprosth, brachial	16.77	NA	6.75	2.70	090
3491F		I	HIV unsure baby of HIV+moms	0.00	0.00	0.00	0.00	XXX
3497F		I	CD4+ cell percentage <15%	0.00	0.00	0.00	0.00	XXX
3498F		I	CD4+ cell percentage >=15%	0.00	0.00	0.00	0.00	XXX
35001		A	Repair defect of artery	20.70	NA	8.89	3.64	090
35002		A	Repair artery rupture, neck	22.12	NA	10.98	3.58	090
35005		A	Repair defect of artery	19.18	NA	13.28	3.46	090
35011		A	Repair defect of artery	18.50	NA	7.69	3.19	090
35013		A	Repair artery rupture, arm	23.10	NA	9.47	3.97	090
35021		A	Repair defect of artery	22.09	NA	9.58	3.93	090
35022		A	Repair artery rupture, chest	25.62	NA	10.66	4.55	090
35045		A	Repair defect of arm artery	17.94	NA	7.94	3.03	090
35081		A	Repair defect of artery	33.37	NA	12.80	5.86	090
35082		A	Repair artery rupture, aorta	41.93	NA	15.63	7.30	090
35091		A	Repair defect of artery	35.35	NA	12.22	6.22	090
35092		A	Repair artery rupture, aorta	50.81	NA	17.93	8.92	090
35102		A	Repair defect of artery	36.37	NA	13.60	6.37	090
35103		A	Repair artery rupture, groin	43.49	NA	15.65	7.53	090
3510F		I	Doc tb scrng-rslts interpd	0.00	0.00	0.00	0.00	XXX
35111		A	Repair defect of artery	26.17	NA	12.37	4.24	090
35112		A	Repair artery rupture,spleen	32.44	NA	14.83	5.25	090
3511F		I	Chlmyd/gonrh tsts docd done	0.00	0.00	0.00	0.00	XXX
35121		A	Repair defect of artery	31.41	NA	11.88	5.50	090
35122		A	Repair artery rupture, belly	37.76	NA	16.81	6.11	090
3512F		I	Syph scrng docd as done	0.00	0.00	0.00	0.00	XXX
35131		A	Repair defect of artery	26.29	NA	10.43	4.60	090
35132		A	Repair artery rupture, groin	32.44	NA	12.15	5.62	090
3513F		I	Hep B scrng docd as done	0.00	0.00	0.00	0.00	XXX
35141		A	Repair defect of artery	20.83	NA	8.31	3.65	090
35142		A	Repair artery rupture, thigh	25.03	NA	9.84	4.38	090
3514F		I	Hep C scrng docd as done	0.00	0.00	0.00	0.00	XXX
35151		A	Repair defect of artery	23.61	NA	9.24	4.13	090
35152		A	Repair artery rupture, knee	27.53	NA	9.23	4.96	090
3515F		I	Pt has docd immun to hep C	0.00	0.00	0.00	0.00	XXX
35180		A	Repair blood vessel lesion	15.01	NA	6.82	2.71	090
35182		A	Repair blood vessel lesion	31.58	NA	15.44	5.11	090
35184		A	Repair blood vessel lesion	18.72	NA	9.41	3.03	090
35188		A	Repair blood vessel lesion	15.05	NA	8.36	2.44	090
35189		A	Repair blood vessel lesion	29.85	NA	11.89	5.67	090
35190		A	Repair blood vessel lesion	13.33	NA	6.32	2.29	090
35201		A	Repair blood vessel lesion	16.84	NA	7.79	2.84	090
35206		A	Repair blood vessel lesion	13.76	NA	6.42	2.29	090
35207		A	Repair blood vessel lesion	10.85	NA	8.22	1.47	090
35211		A	Repair blood vessel lesion	24.50	NA	10.97	4.47	090
35216		A	Repair blood vessel lesion	36.47	NA	15.48	6.52	090
35221		A	Repair blood vessel lesion	26.54	NA	10.73	4.38	090
35226		A	Repair blood vessel lesion	15.22	NA	6.52	2.66	090
35231		A	Repair blood vessel lesion	21.08	NA	10.58	3.16	090
35236		A	Repair blood vessel lesion	17.94	NA	7.78	3.02	090
35241		A	Repair blood vessel lesion	25.50	NA	11.29	4.78	090
35246		A	Repair blood vessel lesion	28.15	NA	9.50	5.08	090
35251		A	Repair blood vessel lesion	31.83	NA	12.33	5.31	090
35256		A	Repair blood vessel lesion	18.98	NA	7.75	3.30	090
35261		A	Repair blood vessel lesion	18.88	NA	8.59	3.53	090
35266		A	Repair blood vessel lesion	15.75	NA	6.83	2.75	090
35271		A	Repair blood vessel lesion	24.50	NA	10.74	4.65	090
35276		A	Repair blood vessel lesion	25.72	NA	10.93	4.57	090
35281		A	Repair blood vessel lesion	29.93	NA	11.78	5.14	090
35286		A	Repair blood vessel lesion	17.06	NA	7.49	2.98	090
35301		A	Rechanneling of artery	19.53	NA	8.08	3.45	090
35302		A	Rechanneling of artery	21.27	NA	8.41	3.71	090
35303		A	Rechanneling of artery	23.52	NA	9.14	4.10	090
35304		A	Rechanneling of artery	24.52	NA	9.41	4.26	090
35305		A	Rechanneling of artery	23.52	NA	9.12	4.11	090
35306		A	Rechanneling of artery	9.25	NA	2.51	1.67	ZZZ
35311		A	Rechanneling of artery	28.52	NA	10.74	5.07	090
35321		A	Rechanneling of artery	16.51	NA	7.11	2.84	090
35331		A	Rechanneling of artery	27.61	NA	10.78	4.86	090
35341		A	Rechanneling of artery	26.10	NA	9.85	4.59	090
35351		A	Rechanneling of artery	24.53	NA	9.43	4.27	090
35355		A	Rechanneling of artery	19.78	NA	7.78	3.45	090
35361		A	Rechanneling of artery	30.11	NA	9.93	5.43	090
35363		A	Rechanneling of artery	32.22	NA	12.39	5.65	090

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CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,4]	Global
35371		A	Rechanneling of artery	15.23	NA	6.45	2.66	090
35372		A	Rechanneling of artery	18.50	NA	7.45	3.23	090
35390		A	Reoperation, carotid add-on	3.19	NA	1.00	0.56	ZZZ
35400		A	Angioscopy	3.00	NA	0.91	0.52	ZZZ
35450		A	Repair arterial blockage	10.05	NA	3.32	1.61	000
35452		A	Repair arterial blockage	6.90	NA	2.46	1.17	000
35454		A	Repair arterial blockage	6.03	NA	2.11	1.00	000
35456		A	Repair arterial blockage	7.34	NA	2.58	1.23	000
35458		A	Repair arterial blockage	9.48	NA	3.36	1.58	000
35459		A	Repair arterial blockage	8.62	NA	2.99	1.46	000
35460		A	Repair venous blockage	6.03	NA	2.25	1.00	000
35470		A	Repair arterial blockage	8.62	48.20	2.93	1.03	000
35471		A	Repair arterial blockage	10.05	47.82	3.45	0.99	000
35472		A	Repair arterial blockage	6.90	36.39	2.41	0.87	000
35473		A	Repair arterial blockage	6.03	35.28	2.13	0.73	000
35474		A	Repair arterial blockage	7.35	47.75	2.54	0.88	000
35475		R	Repair arterial blockage	9.48	39.25	3.20	1.07	000
35476		A	Repair venous blockage	6.03	31.10	2.14	0.60	000
35480		A	Atherectomy, open	11.06	NA	3.21	1.99	000
35481		A	Atherectomy, open	7.60	NA	2.74	1.35	000
35482		A	Atherectomy, open	6.64	NA	2.01	1.20	000
35483		A	Atherectomy, open	8.09	NA	2.99	1.29	000
35484		A	Atherectomy, open	10.42	NA	3.03	1.88	000
35485		A	Atherectomy, open	9.48	NA	3.47	1.50	000
35490		A	Atherectomy, percutaneous	11.06	NA	4.21	1.18	000
35491		A	Atherectomy, percutaneous	7.60	NA	3.06	1.37	000
35492		A	Atherectomy, percutaneous	6.64	NA	2.68	0.74	000
35493		A	Atherectomy, percutaneous	8.09	NA	3.18	0.89	000
35494		A	Atherectomy, percutaneous	10.42	NA	3.97	1.35	000
35495		A	Atherectomy, percutaneous	9.48	NA	3.63	1.08	000
35500		A	Harvest vein for bypass	6.44	NA	2.07	1.13	ZZZ
35501		A	Artery bypass graft	28.99	NA	12.56	5.08	090
35506		A	Artery bypass graft	25.23	NA	9.70	4.55	090
35508		A	Artery bypass graft	25.99	NA	11.00	4.94	090
35509		A	Artery bypass graft	27.99	NA	10.89	5.05	090
35509F		I	Low risk thromboembolism	0.00	0.00	0.00	0.00	XXX
35510		A	Artery bypass graft	24.29	NA	8.11	4.38	090
35511		A	Artery bypass graft	22.12	NA	7.40	3.99	090
35512		A	Artery bypass graft	23.79	NA	7.98	4.29	090
35515		A	Artery bypass graft	25.99	NA	10.80	4.69	090
35516		A	Artery bypass graft	24.11	NA	8.02	4.35	090
35518		A	Artery bypass graft	22.57	NA	7.52	4.07	090
35521		A	Artery bypass graft	24.00	NA	8.27	4.33	090
35522		A	Artery bypass graft	23.05	NA	9.23	4.16	090
35523		A	Artery bypass graft	24.00	NA	9.94	4.33	090
35525		A	Artery bypass graft	21.59	NA	8.65	3.63	090
35526		A	Artery bypass graft	31.47	NA	12.43	5.98	090
3552F		I	High risk for thromboembolism	0.00	0.00	0.00	0.00	XXX
35531		A	Artery bypass graft	38.98	NA	14.36	6.75	090
35533		A	Artery bypass graft	29.79	NA	13.85	4.82	090
35535		A	Artery bypass graft	38.00	NA	14.42	2.04	090
35536		A	Artery bypass graft	33.60	NA	10.88	6.06	090
35537		A	Artery bypass graft	41.75	NA	13.16	7.42	090
35538		A	Artery bypass graft	46.82	NA	14.56	8.44	090
35539		A	Artery bypass graft	43.98	NA	13.77	7.93	090
35540		A	Artery bypass graft	49.20	NA	17.85	8.59	090
35548		A	Artery bypass graft	22.57	NA	7.88	4.07	090
35549		A	Artery bypass graft	24.34	NA	8.36	4.39	090
35551		A	Artery bypass graft	27.72	NA	13.07	4.49	090
35556		A	Artery bypass graft	26.62	NA	10.53	4.64	090
35558		A	Artery bypass graft	23.00	NA	9.44	4.02	090
3555F		I	Pt inr measurement performed	0.00	0.00	0.00	0.00	XXX
35560		A	Artery bypass graft	33.90	NA	12.72	6.11	090
35563		A	Artery bypass graft	25.99	NA	12.44	4.69	090
35565		A	Artery bypass graft	25.00	NA	9.82	4.34	090
35566		A	Artery bypass graft	32.22	NA	12.02	5.66	090
35570		A	Artery bypass graft	29.00	NA	11.62	1.55	090
35571		A	Artery bypass graft	25.39	NA	9.77	4.45	090
35572		A	Harvest femoropopliteal vein	6.81	NA	2.19	1.19	ZZZ
35583		A	Vein bypass graft	27.62	NA	10.73	4.80	090
35585		A	Vein bypass graft	32.22	NA	12.35	5.60	090
35587		A	Vein bypass graft	26.08	NA	10.10	4.56	090
35600		A	Harvest art for cabg add-on	4.94	NA	1.69	0.88	ZZZ
35601		A	Artery bypass graft	26.99	NA	12.22	4.79	090
35606		A	Artery bypass graft	22.36	NA	8.60	3.96	090
35612		A	Artery bypass graft	16.71	NA	6.28	3.01	090
35616		A	Artery bypass graft	21.74	NA	10.29	3.52	090
35621		A	Artery bypass graft	20.95	NA	8.21	3.68	090
35623		A	Bypass graft, not vein	25.79	NA	8.76	4.65	090
35626		A	Artery bypass graft	29.06	NA	11.54	5.28	090
35631		A	Artery bypass graft	35.90	NA	12.53	6.38	090
35632		A	Artery bypass graft	36.00	NA	13.78	1.93	090
35633		A	Artery bypass graft	38.98	NA	14.74	2.09	090

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
35634		A	Artery bypass graft	35.20	NA	13.52	1.89	090
35636		A	Artery bypass graft	31.62	NA	10.34	5.70	090
35637		A	Artery bypass graft	32.92	NA	12.69	5.78	090
35638		A	Artery bypass graft	33.47	NA	12.74	5.91	090
35642		A	Artery bypass graft	18.85	NA	7.16	3.40	090
35645		A	Artery bypass graft	18.34	NA	7.91	3.48	090
35646		A	Artery bypass graft	32.84	NA	12.51	5.74	090
35647		A	Artery bypass graft	29.62	NA	11.26	5.22	090
35650		A	Artery bypass graft	20.08	NA	8.12	3.62	090
35651		A	Artery bypass graft	25.97	NA	12.42	4.21	090
35654		A	Artery bypass graft	26.17	NA	10.10	4.59	090
35656		A	Artery bypass graft	20.39	NA	8.27	3.56	090
35661		A	Artery bypass graft	20.22	NA	8.53	3.53	090
35663		A	Artery bypass graft	23.80	NA	9.38	4.15	090
35665		A	Artery bypass graft	22.22	NA	8.83	3.87	090
35666		A	Artery bypass graft	23.53	NA	10.09	4.12	090
35671		A	Artery bypass graft	20.64	NA	9.03	3.59	090
35681		A	Composite bypass graft	1.60	NA	0.50	0.28	ZZZ
35682		A	Composite bypass graft	7.19	NA	2.14	1.26	ZZZ
35683		A	Composite bypass graft	8.49	NA	2.30	1.53	ZZZ
35685		A	Bypass graft patency/patch	4.04	NA	1.21	0.71	ZZZ
35686		A	Bypass graft/av fist patency	3.34	NA	1.02	0.56	ZZZ
35691		A	Arterial transposition	18.32	NA	6.56	3.30	090
35693		A	Arterial transposition	15.64	NA	6.36	2.82	090
35694		A	Arterial transposition	19.19	NA	6.80	3.46	090
35695		A	Arterial transposition	19.97	NA	7.01	3.60	090
35697		A	Reimplant artery each	3.00	NA	0.91	0.53	ZZZ
35700		A	Reoperation, bypass graft	3.08	NA	0.95	0.54	ZZZ
35701		A	Exploration, carotid artery	9.11	NA	5.39	1.37	090
35721		A	Exploration, femoral artery	7.66	NA	4.19	1.31	090
3572F		I	Pt consid poss risk fx	0.00	0.00	0.00	0.00	XXX
3573F		I	Pt not consid poss risk fx	0.00	0.00	0.00	0.00	XXX
35741		A	Exploration popliteal artery	8.61	NA	4.69	1.46	090
35761		A	Exploration of artery/vein	5.84	NA	4.14	0.97	090
35800		A	Explore neck vessels	7.99	NA	4.75	1.29	090
35820		A	Explore chest vessels	36.81	NA	14.18	6.68	090
35840		A	Explore abdominal vessels	10.87	NA	5.90	1.77	090
35860		A	Explore limb vessels	6.72	NA	3.97	1.16	090
35870		A	Repair vessel graft defect	24.39	NA	8.37	4.40	090
35875		A	Removal of clot in graft	10.64	NA	5.03	1.84	090
35876		A	Removal of clot in graft	17.74	NA	7.30	3.08	090
35879		A	Revise graft w/vein	17.28	NA	7.27	3.03	090

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
35881		A	Revise graft w/vein	19.22	NA	7.68	3.39	090
35883		A	Revise graft w/nonauto graft	23.07	NA	8.82	4.04	090
35884		A	Revise graft w/vein	24.57	NA	8.13	4.43	090
35901		A	Excision, graft, neck	8.26	NA	4.92	1.43	090
35903		A	Excision, graft, extremity	9.44	NA	5.43	1.62	090
35905		A	Excision, graft, thorax	33.39	NA	10.82	6.02	090
35907		A	Excision, graft, abdomen	37.14	NA	13.23	6.50	090
36000		A	Place needle in vein	0.18	0.41	0.07	0.01	XXX
36002		A	Pseudoaneurysm injection trt	1.96	2.12	0.81	0.21	000
36005		A	Injection ext venography	0.95	4.54	0.30	0.08	000
36010		A	Place catheter in vein	2.43	8.54	0.75	0.25	XXX
36011		A	Place catheter in vein	3.14	14.13	1.01	0.28	XXX
36012		A	Place catheter in vein	3.51	13.79	1.10	0.31	XXX
36013		A	Place catheter in artery	2.52	12.62	0.79	0.24	XXX
36014		A	Place catheter in artery	3.02	13.22	0.95	0.23	XXX
36015		A	Place catheter in artery	3.51	13.94	1.09	0.26	XXX
36100		A	Establish access to artery	3.02	7.81	0.97	0.38	XXX
36120		A	Establish access to artery	2.01	7.42	0.58	0.22	XXX
36140		A	Establish access to artery	2.01	7.52	0.63	0.24	XXX
36145		A	Artery to vein shunt	2.01	8.35	0.63	0.18	XXX
36160		A	Establish access to aorta	2.52	7.72	0.76	0.23	XXX
36200		A	Place catheter in aorta	3.02	9.83	0.93	0.40	XXX
36215		A	Place catheter in artery	4.67	16.69	1.54	0.43	XXX
36216		A	Place catheter in artery	5.27	18.01	1.74	0.55	XXX
36217		A	Place catheter in artery	6.29	34.68	2.10	0.69	XXX
36218		A	Place catheter in artery	1.01	3.18	0.33	0.11	ZZZ
36245		A	Place catheter in artery	4.67	16.52	1.53	0.42	XXX
36246		A	Place catheter in artery	5.27	17.20	1.66	0.58	XXX
36247		A	Place catheter in artery	6.29	32.08	1.98	0.71	XXX
36248		A	Place catheter in artery	1.01	2.47	0.31	0.10	ZZZ
36260		A	Insertion of infusion pump	9.82	NA	6.18	1.59	090
36261		A	Revision of infusion pump	5.55	NA	3.55	1.00	090
36262		A	Removal of infusion pump	4.05	NA	3.36	0.60	090
36299		C	Vessel injection procedure	0.00	0.00	0.00	0.00	YYY
36400		A	Bl draw < 3 yrs fem/jugular	0.38	0.37	0.14	0.02	XXX
36405		A	Bl draw < 3 yrs scalp vein	0.31	0.38	0.11	0.05	XXX
36406		A	Bl draw < 3 yrs other vein	0.18	0.31	0.07	0.01	XXX
36410		A	Non-routine bl draw > 3 yrs	0.18	0.35	0.07	0.01	XXX
36415		X	Routine venipuncture	0.00	0.21	NA	0.00	XXX
36416		B	Capillary blood draw	0.00	0.21	NA	0.00	XXX
36420		A	Vein access cutdown < 1 yr	1.01	NA	0.38	0.07	XXX
36425		A	Vein access cutdown > 1 yr	0.76	NA	0.28	0.05	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
36430		A	Blood transfusion service	0.00	0.74	NA	0.00	XXX
36440		A	Bl push transfuse, 2 yr or <	1.03	NA	0.39	0.19	XXX
36450		A	Bl exchange/transfuse, nb	2.23	NA	0.87	0.16	XXX
36455		A	Bl exchange/transfuse non-nb	2.43	NA	0.96	0.11	XXX
36460		A	Transfusion service, fetal	6.58	NA	2.44	1.07	XXX
36468		R	Injection(s), spider veins	0.00	0.00	0.00	0.00	000
36469		R	Injection(s), spider veins	0.00	0.00	0.00	0.00	000
36470		A	Injection therapy of vein	1.09	2.65	0.78	0.13	010
36471		A	Injection therapy of veins	1.60	2.82	0.94	0.21	010
36475		A	Endovenous rf, 1st vein	6.72	39.14	2.39	1.05	000
36476		A	Endovenous rf, vein add-on	3.38	6.71	1.08	0.55	ZZZ
36478		A	Endovenous laser, 1st vein	6.72	27.72	2.36	0.92	000
36479		A	Endovenous laser vein addon	3.38	6.76	1.11	0.48	ZZZ
36481		A	Insertion of catheter, vein	6.98	3.03	NA	0.60	000
36500		A	Insertion of catheter, vein	3.51	NA	1.14	0.39	000
36510		A	Insertion of catheter, vein	1.09	1.28	0.43	0.08	000
36511		A	Apheresis wbc	1.74	NA	0.72	0.10	000
36512		A	Apheresis rbc	1.74	NA	0.71	0.11	000
36513		A	Apheresis platelets	1.74	NA	0.74	0.22	000
36514		A	Apheresis plasma	1.74	10.52	0.65	0.11	000
36515		A	Apheresis, adsorp/reinfuse	1.74	45.35	0.66	0.12	000
36516		A	Apheresis, selective	1.22	47.33	0.46	0.08	000
36522		A	Photopheresis	1.67	29.97	0.99	0.09	000
36555		A	Insert non-tunnel cv cath	2.68	3.64	0.45	0.16	000
36556		A	Insert non-tunnel cv cath	2.50	3.32	0.69	0.22	000
36557		A	Insert tunneled cv cath	5.11	19.99	3.09	0.83	010
36558		A	Insert tunneled cv cath	4.81	14.84	2.42	0.54	010
36560		A	Insert tunneled cv cath	6.26	18.18	2.66	0.45	010
36561		A	Insert tunneled cv cath	6.01	23.75	3.10	0.82	010
36563		A	Insert tunneled cv cath	6.21	26.07	3.32	0.96	010
36565		A	Insert tunneled cv cath	6.01	19.21	2.92	0.96	010
36566		A	Insert tunneled cv cath	6.51	124.70	3.22	0.93	010
36568		A	Insert picc cath	1.92	5.00	0.61	0.14	000
36569		A	Insert picc cath	1.82	4.29	0.62	0.14	000
36570		A	Insert picvad cath	5.33	21.12	2.52	0.39	010
36571		A	Insert picvad cath	5.31	26.80	2.88	0.74	010
36575		A	Repair tunneled cv cath	0.67	3.37	0.25	0.06	000
36576		A	Repair tunneled cv cath	3.21	6.36	1.79	0.43	010
36578		A	Replace tunneled cv cath	3.51	9.29	2.04	0.40	010
36580		A	Replace cvad cath	1.31	4.01	0.46	0.12	000
36581		A	Replace tunneled cv cath	3.45	15.33	1.68	0.30	010
36582		A	Replace tunneled cv cath	5.21	22.46	2.68	0.67	010
36583		A	Replace tunneled cv cath	5.26	28.34	3.15	0.85	010
36584		A	Replace picc cath	1.20	3.79	0.56	0.09	000
36585		A	Replace picvad cath	4.81	22.15	2.42	0.50	010
36589		A	Removal tunneled cv cath	2.27	2.00	1.35	0.26	010
36590		A	Removal tunneled cv cath	3.32	4.08	1.91	0.47	010
36591		T	Draw blood off venous device	0.00	0.51	NA	0.00	XXX
36592		T	Collect blood from picc	0.00	0.57	NA	0.00	XXX
36593		A	Declot vascular device	0.00	0.68	NA	0.00	XXX
36595		A	Mech remov tunneled cv cath	3.59	10.22	1.28	0.30	000
36596		A	Mech remov tunneled cv cath	0.75	2.48	0.41	0.07	000
36597		A	Reposition venous catheter	1.21	1.90	0.40	0.10	000
36598		T	Inj w/fluor, eval cv device	0.74	2.00	0.23	0.05	000
36600		A	Withdrawal of arterial blood	0.32	0.46	0.09	0.02	XXX
36620		A	Insertion catheter, artery	1.15	NA	0.21	0.07	000
36625		A	Insertion catheter, artery	2.11	NA	0.61	0.32	000
36640		A	Insertion catheter, artery	2.10	NA	1.04	0.26	000
36660		A	Insertion catheter, artery	1.40	NA	0.22	0.27	000
36680		A	Insert needle, bone cavity	1.20	NA	0.29	0.12	000
36800		A	Insertion of cannula	2.43	NA	1.77	0.28	000
36810		A	Insertion of cannula	3.96	NA	1.60	0.52	000
36815		A	Insertion of cannula	2.62	NA	1.29	0.42	000
36818		A	Av fuse, uppr arm, cephalic	11.81	NA	5.58	2.01	090
36819		A	Av fuse, uppr arm, basilic	14.39	NA	6.32	2.46	090
36820		A	Av fusion/forearm vein	14.39	NA	6.55	2.44	090
36821		A	Av fusion direct any site	12.00	NA	5.98	2.03	090
36822		A	Insertion of cannula(s)	5.51	NA	4.19	0.97	090
36823		A	Insertion of cannula(s)	22.82	NA	11.08	3.76	090
36825		A	Artery-vein autograft	10.00	NA	5.18	1.68	090
36830		A	Artery-vein nonautograft	12.00	NA	5.14	2.05	090
36831		A	Open thrombect av fistula	8.01	NA	3.93	1.35	090
36832		A	Av fistula revision, open	10.50	NA	4.66	1.78	090
36833		A	Av fistula revision	11.95	NA	5.16	2.03	090
36834		A	Repair A-V aneurysm	11.11	NA	5.17	1.89	090
36835		A	Artery to vein shunt	7.43	NA	5.10	1.34	090
36838		A	Dist revas ligation, hemo	21.59	NA	8.67	3.73	090
36860		A	External cannula declotting	2.01	3.28	0.80	0.15	000
36861		A	Cannula declotting	2.52	NA	1.48	0.36	000
36870		A	Percut thrombect av fistula	5.17	32.07	2.66	0.52	090
37140		A	Revision of circulation	25.12	NA	12.10	4.07	090
37145		A	Revision of circulation	26.13	NA	12.39	4.34	090
37160		A	Revision of circulation	23.13	NA	11.36	4.17	090
37180		A	Revision of circulation	26.13	NA	12.48	4.23	090

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
37181		A	Splice spleen/kidney veins	28.26	NA	13.27	4.58	090
37182		A	Insert hepatic shunt (tips)	16.97	NA	5.21	1.26	000
37183		A	Remove hepatic shunt (tips)	7.99	NA	2.48	0.58	000
37184		A	Prim art mech thrombectomy	8.66	40.87	3.01	0.98	000
37185		A	Prim art m-thrombect add-on	3.28	12.44	1.03	0.38	ZZZ
37186		A	Sec art m-thrombect add-on	4.92	26.45	1.54	0.53	ZZZ
37187		A	Venous mech thrombectomy	8.03	39.69	2.71	0.78	000
37188		A	Venous m-thrombectomy add-on	5.71	34.71	2.00	0.51	000
37195		C	Thrombolytic therapy, stroke	0.00	NA	NA	0.00	XXX
37200		A	Transcatheter biopsy	4.55	NA	1.35	0.33	000
37201		A	Transcatheter therapy infuse	4.99	NA	2.12	0.53	000
37202		A	Transcatheter therapy infuse	5.67	NA	2.75	0.56	000
37203		A	Transcatheter retrieval	5.02	22.14	1.77	0.48	000
37204		A	Transcatheter occlusion	18.11	NA	5.45	1.63	000
37205		A	Transcath iv stent, percut	8.27	88.97	2.63	0.90	000
37206		A	Transcath iv stent/perc addl	4.12	55.62	1.29	0.48	ZZZ
37207		A	Transcath iv stent, open	8.27	NA	2.90	1.40	000
37208		A	Transcath iv stent/open addl	4.12	NA	1.24	0.71	ZZZ
37209		A	Change iv cath at thromb tx	2.27	NA	0.68	0.24	000
37210		A	Embolization uterine fibroid	10.60	70.84	3.20	0.78	000
37215		R	Transcath stent, cca w/eps	19.58	NA	7.68	3.13	090
37216		N	Transcath stent, cca w/o eps	18.85	NA	8.41	1.01	090
37250		A	Iv us first vessel add-on	2.10	NA	0.65	0.28	ZZZ
37251		A	Iv us each add vessel add-on	1.60	NA	0.47	0.25	ZZZ
37500		A	Endoscopy ligate perf veins	11.54	NA	6.49	1.97	090
37501		C	Vascular endoscopy procedure	0.00	0.00	0.00	0.00	YYY
37565		A	Ligation of neck vein	11.97	NA	6.66	1.94	090
37600		A	Ligation of neck artery	12.34	NA	6.25	1.95	090
37605		A	Ligation of neck artery	14.20	NA	6.66	2.52	090
37606		A	Ligation of neck artery	8.72	NA	5.67	1.41	090
37607		A	Ligation of a-v fistula	6.19	NA	3.62	1.03	090
37609		A	Temporal artery procedure	3.02	4.89	2.29	0.42	010
37615		A	Ligation of neck artery	7.72	NA	5.20	1.25	090
37616		A	Ligation of chest artery	18.89	NA	9.24	3.06	090
37617		A	Ligation of abdomen artery	23.71	NA	10.22	3.53	090
37618		A	Ligation of extremity artery	5.95	NA	3.92	1.00	090
37620		A	Revision of major vein	11.49	NA	5.11	1.31	090
37650		A	Revision of major vein	8.41	NA	4.39	1.41	090
37660		A	Revision of major vein	22.20	NA	10.47	3.60	090
37700		A	Revise leg vein	3.76	NA	2.76	0.63	090
37718		A	Ligate/strip short leg vein	7.05	NA	4.26	1.18	090
37722		A	Ligate/strip long leg vein	8.08	NA	4.49	1.35	090

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
37735		A	Removal of leg veins/lesion	10.81	NA	5.31	1.80	090
37760		A	Ligation, leg veins, open	10.69	NA	5.71	1.75	090
37765		A	Phleb veins - extrem - to 20	7.63	NA	4.13	1.18	090
37766		A	Phleb veins - extrem 20+	9.58	NA	4.81	1.52	090
37780		A	Revision of leg vein	3.87	NA	2.85	0.65	090
37785		A	Ligate/divide/excise vein	3.87	5.37	2.91	0.64	090
37788		A	Revascularization, penis	23.21	NA	11.11	3.76	090
37790		A	Penile venous occlusion	8.37	NA	4.21	0.61	090
37799		C	Vascular surgery procedure	0.00	0.00	0.00	0.00	YYY
38100		A	Removal of spleen, total	19.47	NA	9.25	3.06	090
38101		A	Removal of spleen, partial	19.47	NA	9.46	3.15	090
38102		A	Removal of spleen, total	4.79	NA	1.77	0.69	ZZZ
38115		A	Repair of ruptured spleen	21.80	NA	10.09	3.22	090
38120		A	Laparoscopy, splenectomy	16.97	NA	9.23	2.72	090
38129		C	Laparoscope proc, spleen	0.00	0.00	0.00	0.00	YYY
38200		A	Injection for spleen x-ray	2.64	NA	1.05	0.48	000
38204		B	Bl donor search management	2.00	NA	0.73	0.11	XXX
38205		R	Harvest allogenic stem cells	1.50	NA	0.65	0.09	000
38206		R	Harvest auto stem cells	1.50	NA	0.63	0.09	000
38207		I	Cryopreserve stem cells	0.89	NA	0.43	0.05	XXX
38208		I	Thaw preserved stem cells	0.56	NA	0.27	0.03	XXX
38209		I	Wash harvest stem cells	0.24	NA	0.12	0.01	XXX
38210		I	T-cell depletion of harvest	1.57	NA	0.76	0.08	XXX
38211		I	Tumor cell deplete of harvst	1.42	NA	0.69	0.08	XXX
38212		I	Rbc depletion of harvest	0.94	NA	0.45	0.05	XXX
38213		I	Platelet deplete of harvest	0.24	NA	0.12	0.01	XXX
38214		I	Volume deplete of harvest	0.81	NA	0.39	0.04	XXX
38215		I	Harvest stem cell concentrte	0.94	NA	0.45	0.05	XXX
38220		A	Bone marrow aspiration	1.08	2.40	0.50	0.09	XXX
38221		A	Bone marrow biopsy	1.37	2.44	0.63	0.07	XXX
38230		R	Bone marrow collection	4.80	NA	3.55	0.73	010
38240		R	Bone marrow/stem transplant	2.24	NA	1.03	0.12	XXX
38241		R	Bone marrow/stem transplant	2.24	NA	1.05	0.12	XXX
38242		A	Lymphocyte infuse transplant	1.71	NA	0.82	0.08	000
38300		A	Drainage, lymph node lesion	2.28	4.35	2.21	0.26	010
38305		A	Drainage, lymph node lesion	6.55	NA	4.90	0.97	090
38308		A	Incision of lymph channels	6.73	NA	4.48	1.08	090
38380		A	Thoracic duct procedure	8.34	NA	6.54	0.81	090
38381		A	Thoracic duct procedure	13.32	NA	6.76	2.37	090
38382		A	Thoracic duct procedure	10.51	NA	7.11	1.70	090
38500		A	Biopsy/removal, lymph nodes	3.76	4.46	2.56	0.58	010
38505		A	Needle biopsy, lymph nodes	1.14	2.00	0.71	0.09	000

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CPT[1]/HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
38510		A	Biopsy/removal, lymph nodes	6.69	6.43	3.99	0.82	010
38520		A	Biopsy/removal, lymph nodes	6.95	NA	4.66	1.06	090
38525		A	Biopsy/removal, lymph nodes	6.35	NA	4.41	1.02	090
38530		A	Biopsy/removal, lymph nodes	8.26	NA	5.33	1.37	090
38542		A	Explore deep node(s), neck	7.85	NA	5.39	1.00	090
38550		A	Removal, neck/armpit lesion	6.99	NA	5.48	1.13	090
38555		A	Removal, neck/armpit lesion	15.42	NA	9.07	2.50	090
38562		A	Removal, pelvic lymph nodes	10.92	NA	6.51	1.29	090
38564		A	Removal, abdomen lymph nodes	11.29	NA	6.34	1.59	090
38570		A	Laparoscopy, lymph node biop	9.28	NA	4.42	0.95	010
38571		A	Laparoscopy, lymphadenectomy	14.70	NA	5.91	1.05	010
38572		A	Laparoscopy, lymphadenectomy	16.86	NA	7.47	1.00	010
38589		C	Laparoscope proc, lymphatic	0.00	0.00	0.00	0.00	YYY
38700		A	Removal of lymph nodes, neck	12.68	NA	8.32	1.30	090
38720		A	Removal of lymph nodes, neck	21.72	NA	12.97	2.48	090
38724		A	Removal of lymph nodes, neck	23.72	NA	14.21	2.48	090
38740		A	Remove armpit lymph nodes	10.57	NA	6.50	1.70	090
38745		A	Remove armpit lymph nodes	13.71	NA	7.93	2.20	090
38746		A	Remove thoracic lymph nodes	4.88	NA	1.58	0.86	ZZZ
38747		A	Remove abdominal lymph nodes	4.88	NA	1.80	0.77	ZZZ
38760		A	Remove groin lymph nodes	13.49	NA	7.43	1.96	090
38765		A	Remove groin lymph nodes	21.78	NA	10.56	3.10	090
38770		A	Remove pelvis lymph nodes	13.98	NA	6.63	1.23	090
38780		A	Remove abdomen lymph nodes	17.56	NA	8.68	1.68	090
38790		A	Inject for lymphatic x-ray	1.29	NA	0.82	0.18	000
38792		A	Identify sentinel node	0.52	NA	0.51	0.07	000
38794		A	Access thoracic lymph duct	4.51	NA	2.82	0.33	090
38999		C	Blood/lymph system procedure	0.00	0.00	0.00	0.00	YYY
39000		A	Exploration of chest	7.49	NA	4.96	1.27	090
39010		A	Exploration of chest	13.11	NA	6.77	2.36	090
39200		A	Removal chest lesion	15.04	NA	7.06	2.67	090
39220		A	Removal chest lesion	19.47	NA	9.27	3.34	090
39400		A	Visualization of chest	8.00	NA	4.67	1.40	010
39499		C	Chest procedure	0.00	0.00	0.00	0.00	YYY
39501		A	Repair diaphragm laceration	13.89	NA	7.33	2.21	090
39502		A	Repair paraesophageal hernia	17.09	NA	8.73	2.76	090
39503		A	Repair of diaphragm hernia	108.67	NA	19.79	17.60	090
39520		A	Repair of diaphragm hernia	16.63	NA	8.35	2.80	090
39530		A	Repair of diaphragm hernia	16.22	NA	7.93	2.71	090
39531		A	Repair of diaphragm hernia	17.23	NA	8.78	2.79	090
39540		A	Repair of diaphragm hernia	14.51	NA	7.25	2.35	090
39541		A	Repair of diaphragm hernia	15.67	NA	7.95	2.56	090
39545		A	Revision of diaphragm	14.58	NA	7.80	2.59	090
39560		A	Resect diaphragm, simple	12.97	NA	6.80	1.94	090
39561		A	Resect diaphragm, complex	19.75	NA	11.54	3.22	090
39599		C	Diaphragm surgery procedure	0.00	0.00	0.00	0.00	YYY
40490		A	Biopsy of lip	1.22	2.01	0.72	0.07	000
40500		A	Partial excision of lip	4.35	8.26	4.85	0.46	090
40510		A	Partial excision of lip	4.74	7.34	4.30	0.45	090
40520		A	Partial excision of lip	4.71	7.56	4.43	0.51	090
40525		A	Reconstruct lip with flap	7.61	NA	6.54	0.91	090
40527		A	Reconstruct lip with flap	9.20	NA	7.00	0.90	090
40530		A	Partial removal of lip	5.45	8.27	4.97	0.63	090
40650		A	Repair lip	3.69	6.77	3.66	0.46	090
40652		A	Repair lip	4.32	7.94	4.62	0.55	090
40654		A	Repair lip	5.37	8.84	5.38	0.66	090
40700		A	Repair cleft lip/nasal	13.97	NA	9.73	1.36	090
40701		A	Repair cleft lip/nasal	17.03	NA	11.17	1.66	090
40702		A	Repair cleft lip/nasal	14.09	NA	7.62	0.75	090
40720		A	Repair cleft lip/nasal	14.54	NA	11.96	2.18	090
40761		A	Repair cleft lip/nasal	15.69	NA	12.36	2.35	090
40799		C	Lip surgery procedure	0.00	0.00	0.00	0.00	YYY
40800		A	Drainage of mouth lesion	1.19	3.85	2.00	0.05	010
40801		A	Drainage of mouth lesion	2.57	4.95	2.82	0.12	010
40804		A	Removal, foreign body, mouth	1.26	4.19	2.14	0.08	010
40805		A	Removal, foreign body, mouth	2.73	5.39	3.24	0.18	010
40806		A	Incision of lip fold	0.31	2.24	0.56	0.01	000
40808		A	Biopsy of mouth lesion	0.98	3.55	1.70	0.05	010
40810		A	Excision of mouth lesion	1.33	3.73	1.87	0.07	010
40812		A	Excise/repair mouth lesion	2.33	4.63	2.55	0.09	010
40814		A	Excise/repair mouth lesion	3.45	5.95	4.11	0.18	090
40816		A	Excision of mouth lesion	3.70	6.24	4.24	0.24	090
40818		A	Excise oral mucosa for graft	2.72	6.09	4.06	0.21	090
40819		A	Excise lip or cheek fold	2.45	5.10	3.41	0.12	090
40820		A	Treatment of mouth lesion	1.30	5.22	2.99	0.07	010
40830		A	Repair mouth laceration	1.78	4.56	2.30	0.15	010
40831		A	Repair mouth laceration	2.50	5.71	3.05	0.22	010
40840		R	Reconstruction of mouth	9.03	11.23	6.76	0.88	090
40842		R	Reconstruction of mouth	9.03	13.27	8.23	0.88	090
40843		R	Reconstruction of mouth	12.62	12.86	7.24	0.68	090
40844		R	Reconstruction of mouth	16.57	16.43	10.60	2.48	090
40845		R	Reconstruction of mouth	19.13	18.55	12.88	1.87	090
40899		C	Mouth surgery procedure	0.00	0.00	0.00	0.00	YYY
41000		A	Drainage of mouth lesion	1.32	2.64	1.47	0.07	010

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
41005		A	Drainage of mouth lesion	1.28	4.55	1.97	0.08	010
41006		A	Drainage of mouth lesion	3.28	5.94	3.30	0.32	090
41007		A	Drainage of mouth lesion	3.14	5.92	3.24	0.31	090
41008		A	Drainage of mouth lesion	3.40	5.60	3.15	0.18	090
41009		A	Drainage of mouth lesion	3.63	5.91	3.50	0.14	090
41010		A	Incision of tongue fold	1.08	4.10	1.73	0.07	010
41015		A	Drainage of mouth lesion	4.00	6.93	4.85	0.11	090
41016		A	Drainage of mouth lesion	4.11	6.94	4.98	0.11	090
41017		A	Drainage of mouth lesion	4.11	6.27	4.30	0.15	090
41018		A	Drainage of mouth lesion	5.14	7.65	5.61	0.14	090
41019		A	Place needles h&n for rt	8.84	NA	3.66	0.55	000
41100		A	Biopsy of tongue	1.39	2.79	1.35	0.08	010
41105		A	Biopsy of tongue	1.44	2.79	1.38	0.08	010
41108		A	Biopsy of floor of mouth	1.07	2.60	1.22	0.06	010
41110		A	Excision of tongue lesion	1.53	3.81	1.84	0.09	010
41112		A	Excision of tongue lesion	2.77	5.42	3.52	0.18	090
41113		A	Excision of tongue lesion	3.23	5.75	3.77	0.20	090
41114		A	Excision of tongue lesion	8.71	NA	7.46	0.64	090
41115		A	Excision of tongue fold	1.76	4.46	2.17	0.11	010
41116		A	Excision of mouth lesion	2.47	5.72	3.08	0.19	090
41120		A	Partial removal of tongue	10.91	NA	15.84	1.07	090
41130		A	Partial removal of tongue	15.51	NA	17.93	1.53	090
41135		A	Tongue and neck surgery	29.83	NA	26.03	2.97	090
41140		A	Removal of tongue	28.81	NA	27.91	2.81	090
41145		A	Tongue removal, neck surgery	37.59	NA	34.38	3.67	090
41150		A	Tongue, mouth, jaw surgery	29.52	NA	27.27	2.92	090
41153		A	Tongue, mouth, neck surgery	33.28	NA	28.68	3.24	090
41155		A	Tongue, jaw, & neck surgery	43.96	NA	33.50	4.28	090
41250		A	Repair tongue laceration	1.93	4.46	1.92	0.18	010
41251		A	Repair tongue laceration	2.29	4.65	2.15	0.15	010
41252		A	Repair tongue laceration	2.99	5.02	2.49	0.26	010
41500		A	Fixation of tongue	3.74	NA	8.04	0.36	090
41510		A	Tongue to lip surgery	3.45	NA	7.30	0.34	090
41512		A	Tongue suspension	6.75	NA	9.70	0.36	090
41520		A	Reconstruction, tongue fold	2.77	6.12	3.82	0.08	090
41530		A	Tongue base vol reduction	4.38	74.78	6.07	0.23	010
41599		C	Tongue and mouth surgery	0.00	0.00	0.00	0.00	YYY
41800		A	Drainage of gum lesion	1.21	5.18	2.34	0.09	010
41805		A	Removal foreign body, gum	1.28	4.84	2.99	0.03	010
41806		A	Removal foreign body,jawbone	2.73	6.19	3.92	0.07	010
41820		R	Excision, gum, each quadrant	0.00	0.00	0.00	0.00	000
41821		R	Excision of gum flap	0.00	0.00	0.00	0.00	000
41822		R	Excision of gum lesion	2.35	4.98	2.36	0.06	010
41823		R	Excision of gum lesion	3.63	7.11	4.60	0.10	090
41825		A	Excision of gum lesion	1.35	3.65	1.61	0.06	010
41826		A	Excision of gum lesion	2.35	5.07	2.80	0.08	010
41827		A	Excision of gum lesion	3.72	7.04	3.96	0.21	090
41828		R	Excision of gum lesion	3.11	4.74	2.49	0.08	010
41830		R	Removal of gum tissue	3.38	6.56	3.93	0.09	010
41850		R	Treatment of gum lesion	0.00	0.00	0.00	0.00	000
41870		R	Gum graft	0.00	0.00	0.00	0.00	000
41872		R	Repair gum	2.90	6.24	3.76	0.08	090
41874		R	Repair tooth socket	3.13	5.87	3.20	0.10	090
41899		C	Dental surgery procedure	0.00	0.00	0.00	0.00	YYY
42000		A	Drainage mouth roof lesion	1.25	2.71	1.43	0.08	010
42100		A	Biopsy roof of mouth	1.33	2.39	1.43	0.07	010
42104		A	Excision lesion, mouth roof	1.66	3.69	1.87	0.09	010
42106		A	Excision lesion, mouth roof	2.12	4.50	2.32	0.09	010
42107		A	Excision lesion, mouth roof	4.48	7.00	4.31	0.29	090
42120		A	Remove palate/lesion	11.70	NA	13.87	1.13	090
42140		A	Excision of uvula	1.65	4.81	2.35	0.16	090
42145		A	Repair palate, pharynx/uvula	9.63	NA	8.76	0.94	090
42160		A	Treatment mouth roof lesion	1.82	4.00	1.94	0.11	010
42180		A	Repair palate	2.52	3.82	2.31	0.16	010
42182		A	Repair palate	3.84	4.54	2.93	0.25	010
42200		A	Reconstruct cleft palate	12.41	NA	9.96	1.21	090
42205		A	Reconstruct cleft palate	13.57	NA	9.88	1.32	090
42210		A	Reconstruct cleft palate	14.91	NA	12.79	0.41	090
42215		A	Reconstruct cleft palate	8.88	NA	8.01	1.33	090
42220		A	Reconstruct cleft palate	7.07	NA	5.11	0.19	090
42225		A	Reconstruct cleft palate	9.66	NA	13.16	0.94	090
42226		A	Lengthening of palate	10.24	NA	13.02	1.00	090
42227		A	Lengthening of palate	9.81	NA	12.04	0.96	090
42235		A	Repair palate	7.92	NA	11.15	0.77	090
42260		A	Repair nose to lip fistula	10.10	11.07	7.27	0.98	090
42280		A	Preparation, palate mold	1.56	2.59	1.29	0.04	010
42281		A	Insertion, palate prosthesis	1.95	3.36	2.01	0.13	010
42299		C	Palate/uvula surgery	0.00	0.00	0.00	0.00	YYY
42300		A	Drainage of salivary gland	1.95	3.41	2.00	0.14	010
42305		A	Drainage of salivary gland	6.23	NA	4.96	0.59	090
42310		A	Drainage of salivary gland	1.58	2.59	1.66	0.10	010
42320		A	Drainage of salivary gland	2.37	4.10	2.24	0.15	010
42330		A	Removal of salivary stone	2.23	3.68	2.04	0.13	010
42335		A	Removal of salivary stone	3.35	6.15	3.30	0.29	090

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42340		A	Removal of salivary stone	4.64	7.37	4.15	0.45	090
42400		A	Biopsy of salivary gland	0.78	2.00	0.70	0.05	000
42405		A	Biopsy of salivary gland	3.31	4.31	2.56	0.23	010
42408		A	Excision of salivary cyst	4.58	7.12	3.95	0.40	090
42409		A	Drainage of salivary cyst	2.85	5.73	2.94	0.28	090
42410		A	Excise parotid gland/lesion	9.46	NA	6.68	1.07	090
42415		A	Excise parotid gland/lesion	17.99	NA	11.18	1.82	090
42420		A	Excise parotid gland/lesion	20.87	NA	12.52	2.11	090
42425		A	Excise parotid gland/lesion	13.31	NA	8.63	1.37	090
42426		A	Excise parotid gland/lesion	22.54	NA	13.05	2.35	090
42440		A	Excise submaxillary gland	6.88	NA	5.06	0.71	090
42450		A	Excise sublingual gland	4.66	6.92	4.62	0.44	090
42500		A	Repair salivary duct	4.34	6.45	4.28	0.36	090
42505		A	Repair salivary duct	6.23	8.11	5.56	0.61	090
42507		A	Parotid duct diversion	6.16	NA	7.21	0.60	090
42508		A	Parotid duct diversion	9.22	NA	9.42	0.90	090
42509		A	Parotid duct diversion	11.65	NA	10.56	1.74	090
42510		A	Parotid duct diversion	8.26	NA	8.20	0.81	090
42550		A	Injection for salivary x-ray	1.25	2.03	0.37	0.09	000
42600		A	Closure of salivary fistula	4.86	7.54	4.25	0.47	090
4260F		I	Wound srfc culturetech used	0.00	0.00	0.00	0.00	XXX
4261F		I	Tech other than surfc cultr	0.00	0.00	0.00	0.00	XXX
42650		A	Dilation of salivary duct	0.77	1.39	0.77	0.05	000
4265F		I	Wet-dry dressings Rx-recmd	0.00	0.00	0.00	0.00	XXX
42660		A	Dilation of salivary duct	1.13	1.66	0.95	0.06	000
42665		A	Ligation of salivary duct	2.57	5.49	2.81	0.25	090
4266F		I	No wet-dry drssings Rx-recmd	0.00	0.00	0.00	0.00	XXX
4268F		I	Pt ed re comp thxpy rcvd	0.00	0.00	0.00	0.00	XXX
42699		C	Salivary surgery procedure	0.00	0.00	0.00	0.00	YYY
4269F		I	Appropos mthd offloading Rxd	0.00	0.00	0.00	0.00	XXX
42700		A	Drainage of tonsil abscess	1.64	3.22	1.88	0.11	010
4270F		I	Pt rcvng anti r-viral thxpy	0.00	0.00	0.00	0.00	XXX
4271F		I	Pt rcvng anti r-viral thxpy	0.00	0.00	0.00	0.00	XXX
42720		A	Drainage of throat abscess	6.31	5.54	4.02	0.42	010
42725		A	Drainage of throat abscess	12.28	NA	8.80	1.22	090
4275F		I	Hep b vac inj admin/ rcvd	0.00	0.00	0.00	0.00	XXX
4279F		I	PCP prophylaxis Rxd	0.00	0.00	0.00	0.00	XXX
42800		A	Biopsy of throat	1.41	2.66	1.49	0.09	010
42802		A	Biopsy of throat	1.56	4.37	1.90	0.11	010
42804		A	Biopsy of upper nose/throat	1.26	3.78	1.68	0.08	010
42806		A	Biopsy of upper nose/throat	1.60	4.06	1.83	0.11	010
42808		A	Excise pharynx lesion	2.32	3.56	1.93	0.15	010

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42809		A	Remove pharynx foreign body	1.83	2.55	1.58	0.14	010
4280F		I	PCP prophylax Rxd 3mon low %	0.00	0.00	0.00	0.00	XXX
42810		A	Excision of neck cyst	3.30	6.69	4.20	0.32	090
42815		A	Excision of neck cyst	7.23	NA	7.29	0.74	090
42820		A	Remove tonsils and adenoids	4.17	NA	3.45	0.41	090
42821		A	Remove tonsils and adenoids	4.31	NA	3.59	0.42	090
42825		A	Removal of tonsils	3.45	NA	3.38	0.34	090
42826		A	Removal of tonsils	3.40	NA	3.16	0.33	090
42830		A	Removal of adenoids	2.60	NA	2.80	0.25	090
42831		A	Removal of adenoids	2.75	NA	3.04	0.27	090
42835		A	Removal of adenoids	2.33	NA	2.67	0.23	090
42836		A	Removal of adenoids	3.21	NA	3.08	0.31	090
42842		A	Extensive surgery of throat	12.02	NA	13.78	1.18	090
42844		A	Extensive surgery of throat	17.57	NA	18.07	1.71	090
42845		A	Extensive surgery of throat	32.35	NA	25.97	3.15	090
42860		A	Excision of tonsil tags	2.25	NA	2.63	0.22	090
42870		A	Excision of lingual tonsil	5.44	NA	9.48	0.53	090
42890		A	Partial removal of pharynx	18.92	NA	17.92	1.89	090
42892		A	Revision of pharyngeal walls	25.77	NA	23.09	2.56	090
42894		A	Revision of pharyngeal walls	33.61	NA	28.34	3.32	090
42900		A	Repair throat wound	5.26	NA	3.71	0.34	010
4290F		I	Pt scrned for inj drug use	0.00	0.00	0.00	0.00	XXX
4293F		I	Pt scrnd - hgh-rsk sex behav	0.00	0.00	0.00	0.00	XXX
42950		A	Reconstruction of throat	8.16	NA	12.28	0.84	090
42953		A	Repair throat, esophagus	9.33	NA	15.23	0.97	090
42955		A	Surgical opening of throat	7.92	NA	11.59	0.77	090
42960		A	Control throat bleeding	2.35	NA	2.07	0.14	010
42961		A	Control throat bleeding	5.69	NA	5.30	0.55	090
42962		A	Control throat bleeding	7.31	NA	6.23	0.70	090
42970		A	Control nose/throat bleeding	5.76	NA	4.52	0.50	090
42971		A	Control nose/throat bleeding	6.54	NA	5.50	0.64	090
42972		A	Control nose/throat bleeding	7.53	NA	5.96	0.73	090
42999		C	Throat surgery procedure	0.00	0.00	0.00	0.00	YYY
4300F		I	Pt rcvng warf thxpy	0.00	0.00	0.00	0.00	XXX
4301F		I	Pt not rcvng warf thxpy	0.00	0.00	0.00	0.00	XXX
43020		A	Incision of esophagus	8.14	NA	6.05	0.79	090
43030		A	Throat muscle surgery	7.91	NA	5.60	0.87	090
43045		A	Incision of esophagus	21.70	NA	10.62	3.86	090
4305F		I	Pt ed re ft care inspct rcvd	0.00	0.00	0.00	0.00	XXX
4306F		I	Pt tlk psych & Rx opd addic	0.00	0.00	0.00	0.00	XXX
43100		A	Excision of esophagus lesion	9.55	NA	6.94	0.93	090
43101		A	Excision of esophagus lesion	16.99	NA	8.08	3.02	090

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CPT[1,3] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
43107		A	Removal of esophagus	43.97	NA	19.73	7.46	090
43108		A	Removal of esophagus	82.66	NA	34.36	14.69	090
43112		A	Removal of esophagus	47.27	NA	20.04	8.11	090
43113		A	Removal of esophagus	79.85	NA	34.53	12.93	090
43116		A	Partial removal of esophagus	92.78	NA	46.78	9.05	090
43117		A	Partial removal of esophagus	43.52	NA	18.36	7.46	090
43118		A	Partial removal of esophagus	66.86	NA	23.77	10.83	090
43121		A	Partial removal of esophagus	51.22	NA	20.07	9.10	090
43122		A	Partial removal of esophagus	43.97	NA	20.13	7.28	090
43123		A	Partial removal of esophagus	82.91	NA	35.67	13.43	090
43124		A	Removal of esophagus	68.83	NA	26.18	12.23	090
43130		A	Removal of esophagus pouch	12.41	NA	7.99	1.50	090
43135		A	Removal of esophagus pouch	26.09	NA	11.37	4.51	090
43200		A	Esophagus endoscopy	1.59	3.81	1.13	0.12	000
43201		A	Esoph scope w/submucous inj	2.09	5.19	1.20	0.15	000
43202		A	Esophagus endoscopy, biopsy	1.89	5.12	1.08	0.15	000
43204		A	Esoph scope w/sclerosis inj	3.76	NA	1.92	0.29	000
43205		A	Esophagus endoscopy/ligation	3.78	NA	1.92	0.27	000
4320F		I	Pt talk psychsoc+rx oh dpnd	0.00	0.00	0.00	0.00	XXX
43215		A	Esophagus endoscopy	2.60	NA	1.37	0.24	000
43216		A	Esophagus endoscopy/lesion	2.40	3.06	1.30	0.24	000
43217		A	Esophagus endoscopy	2.90	6.41	1.48	0.28	000
43219		A	Esophagus endoscopy	2.80	NA	1.54	0.27	000
43220		A	Esoph endoscopy, dilation	2.10	NA	1.18	0.17	000
43226		A	Esoph endoscopy, dilation	2.34	NA	1.27	0.20	000
43227		A	Esoph endoscopy, repair	3.59	NA	1.80	0.28	000
43228		A	Esoph endoscopy, ablation	3.76	NA	1.90	0.29	000
43231		A	Esoph endoscopy w/us exam	3.19	NA	1.65	0.24	000
43232		A	Esoph endoscopy w/us fn bx	4.47	NA	2.17	0.36	000
43234		A	Upper GI endoscopy, exam	2.01	4.90	1.09	0.20	000
43235		A	Uppr gi endoscopy, diagnosis	2.39	4.80	1.30	0.19	000
43236		A	Uppr gi scope w/submuc inj	2.92	5.96	1.55	0.21	000
43237		A	Endoscopic us exam, esoph	3.98	NA	2.00	0.29	000
43238		A	Uppr gi endoscopy w/us fn bx	5.02	NA	2.44	0.38	000
43239		A	Upper GI endoscopy, biopsy	2.87	5.52	1.51	0.22	000
43240		A	Esoph endoscope w/drain cyst	6.85	NA	3.26	0.49	000
43241		A	Upper GI endoscopy with tube	2.59	NA	1.39	0.21	000
43242		A	Uppr gi endoscopy w/us fn bx	7.30	NA	3.48	0.50	000
43243		A	Upper gi endoscopy & inject	4.56	NA	2.26	0.33	000
43244		A	Upper GI endoscopy/ligation	5.04	NA	2.49	0.35	000
43245		A	Uppr gi scope dilate stricture	3.18	NA	1.62	0.27	000
43246		A	Place gastrostomy tube	4.32	NA	2.10	0.39	000
43247		A	Operative upper GI endoscopy	3.38	NA	1.73	0.27	000
43248		A	Uppr gi endoscopy/guide wire	3.15	NA	1.65	0.22	000
43249		A	Esoph endoscopy, dilation	2.90	NA	1.54	0.21	000
43250		A	Upper GI endoscopy/tumor	3.20	NA	1.63	0.29	000
43251		A	Operative upper GI endoscopy	3.69	NA	1.87	0.28	000
43255		A	Operative upper GI endoscopy	4.81	NA	2.38	0.34	000
43256		A	Uppr gi endoscopy w/stent	4.34	NA	2.13	0.35	000
43257		A	Uppr gi scope w/thrml txmnt	5.50	NA	2.76	0.37	000
43258		A	Operative upper GI endoscopy	4.54	NA	2.25	0.33	000
43259		A	Endoscopic ultrasound exam	5.19	NA	2.55	0.36	000
43260		A	Endo cholangiopancreatograph	5.95	NA	2.88	0.41	000
43261		A	Endo cholangiopancreatograph	6.26	NA	3.02	0.43	000
43262		A	Endo cholangiopancreatograph	7.38	NA	3.52	0.51	000
43263		A	Endo cholangiopancreatograph	7.28	NA	3.44	0.50	000
43264		A	Endo cholangiopancreatograph	8.89	NA	4.19	0.61	000
43265		A	Endo cholangiopancreatograph	10.00	NA	4.68	0.69	000
43267		A	Endo cholangiopancreatograph	7.38	NA	3.50	0.51	000
43268		A	Endo cholangiopancreatograph	7.38	NA	3.65	0.51	000
43269		A	Endo cholangiopancreatograph	8.20	NA	3.88	0.57	000
43271		A	Endo cholangiopancreatograph	7.38	NA	3.51	0.51	000
43272		A	Endo cholangiopancreatograph	7.38	NA	3.53	0.50	000
43273		A	Endoscopic pancreatoscopy	2.24	NA	0.98	0.15	ZZZ
43279		A	Lap myotomy, heller	22.00	NA	10.46	3.55	090
43280		A	Laparoscopy, fundoplasty	18.00	NA	8.95	2.90	090
43289		C	Laparoscope proc, esoph	0.00	0.00	0.00	0.00	YYY
43300		A	Repair of esophagus	9.21	NA	6.95	0.90	090
43305		A	Repair esophagus and fistula	17.98	NA	10.94	1.75	090
43310		A	Repair of esophagus	26.18	NA	11.70	4.65	090
43312		A	Repair esophagus and fistula	29.23	NA	10.70	5.19	090
43313		A	Esophagoplasty congenital	48.17	NA	19.86	2.58	090
43314		A	Tracheo-esophagoplasty cong	53.15	NA	28.62	5.18	090
43320		A	Fuse esophagus & stomach	23.18	NA	11.32	3.75	090
43324		A	Revise esophagus & stomach	22.86	NA	10.98	3.76	090
43325		A	Revise esophagus & stomach	22.47	NA	11.19	3.64	090
43326		A	Revise esophagus & stomach	22.15	NA	10.96	3.83	090
43330		A	Repair of esophagus	22.06	NA	10.70	3.61	090
43331		A	Repair of esophagus	22.93	NA	10.46	4.07	090
43340		A	Fuse esophagus & intestine	22.86	NA	11.33	3.70	090
43341		A	Fuse esophagus & intestine	24.10	NA	12.72	3.90	090
43350		A	Surgical opening, esophagus	19.31	NA	10.59	3.13	090
43351		A	Surgical opening, esophagus	21.87	NA	10.84	3.89	090
43352		A	Surgical opening, esophagus	17.68	NA	8.86	3.14	090

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CPT[1,3] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
43360		A	Gastrointestinal repair	39.90	NA	16.26	7.09	090
43361		A	Gastrointestinal repair	45.50	NA	21.43	7.37	090
43400		A	Ligate esophagus veins	25.47	NA	13.81	2.84	090
43401		A	Esophagus surgery for veins	26.36	NA	12.63	4.27	090
43405		A	Ligate/staple esophagus	24.55	NA	13.65	3.98	090
43410		A	Repair esophagus wound	16.28	NA	8.43	2.89	090
43415		A	Repair esophagus wound	28.70	NA	14.26	4.96	090
43420		A	Repair esophagus openng	16.65	NA	10.29	1.62	090
43425		A	Repair esophagus opening	24.91	NA	13.02	4.03	090
43450		A	Dilate esophagus	1.38	2.41	0.87	0.10	000
43453		A	Dilate esophagus	1.51	5.53	0.93	0.11	000
43456		A	Dilate esophagus	2.57	11.65	1.39	0.19	000
43458		A	Dilate esophagus	3.06	6.42	1.60	0.23	000
43460		A	Pressure treatment esophagus	3.79	NA	1.94	0.26	000
43496		C	Free jejunum flap, microvasc	0.00	0.00	0.00	0.00	090
43499		C	Esophagus surgery procedure	0.00	0.00	0.00	0.00	YYY
43500		A	Surgical opening of stomach	12.71	NA	6.81	2.01	090
43501		A	Surgical repair of stomach	22.47	NA	10.96	3.61	090
43502		A	Surgical repair of stomach	25.56	NA	12.29	4.14	090
43510		A	Surgical opening of stomach	15.01	NA	9.10	2.43	090
43520		A	Incision of pyloric muscle	11.21	NA	5.91	1.89	090
43600		A	Biopsy of stomach	1.91	NA	0.80	0.15	000
43605		A	Biopsy of stomach	13.64	NA	7.13	2.17	090
43610		A	Excision of stomach lesion	16.26	NA	8.16	2.59	090
43611		A	Excision of stomach lesion	20.25	NA	10.16	3.22	090
43620		A	Removal of stomach	33.91	NA	15.12	5.47	090
43621		A	Removal of stomach	39.40	NA	17.20	6.35	090
43622		A	Removal of stomach	39.90	NA	17.43	6.46	090
43631		A	Removal of stomach, partial	24.38	NA	11.72	3.91	090
43632		A	Removal of stomach, partial	35.01	NA	15.66	5.62	090
43633		A	Removal of stomach, partial	33.01	NA	14.85	5.28	090
43634		A	Removal of stomach, partial	36.51	NA	16.36	5.91	090
43635		A	Removal of stomach, partial	2.06	NA	0.76	0.33	ZZZ
43640		A	Vagotomy & pylorus repair	19.43	NA	9.93	3.10	090
43641		A	Vagotomy & pylorus repair	19.68	NA	10.11	3.19	090
43644		A	Lap gastric bypass/roux-en-y	29.24	NA	13.95	4.71	090
43645		A	Lap gastr bypass incl smll i	31.37	NA	14.83	5.08	090
43647		C	Lap impl electrode, antrum	0.00	0.00	0.00	0.00	YYY
43648		C	Lap revise/remv elctrd antrum	0.00	0.00	0.00	0.00	YYY
43651		A	Laparoscopy, vagus nerve	10.13	NA	6.18	1.64	090
43652		A	Laparoscopy, vagus nerve	12.13	NA	6.92	1.96	090
43653		A	Laparoscopy, gastrostomy	8.38	NA	5.75	1.35	090
43659		C	Laparoscope proc, stom	0.00	0.00	0.00	0.00	YYY
43752		A	Nasal/orogastric w/stent	0.81	NA	0.26	0.06	000
43760		A	Change gastrostomy tube	0.90	10.44	0.34	0.09	000
43761		A	Reposition gastrostomy tube	2.01	1.01	0.68	0.16	000
43770		A	Lap place gastr adj device	17.85	NA	9.92	2.87	090
43771		A	Lap revise gastr adj device	20.64	NA	11.01	3.34	090
43772		A	Lap rmvl gastr adj device	15.62	NA	8.11	2.53	090
43773		A	Lap replace gastr adj device	20.64	NA	11.01	3.34	090
43774		A	Lap rmvl gastr adj all parts	15.66	NA	8.22	2.53	090
43800		A	Reconstruction of pylorus	15.35	NA	7.82	2.49	090
43810		A	Fusion of stomach and bowel	16.80	NA	8.47	2.72	090
43820		A	Fusion of stomach and bowel	22.40	NA	10.98	3.59	090
43825		A	Fusion of stomach and bowel	21.63	NA	10.73	3.50	090
43830		A	Place gastrostomy tube	10.75	NA	6.62	1.68	090
43831		A	Place gastrostomy tube	8.38	NA	6.29	1.36	090
43832		A	Place gastrostomy tube	17.26	NA	8.96	2.71	090
43840		A	Repair of stomach lesion	22.70	NA	11.09	3.63	090
43842		N	V-band gastroplasty	20.90	NA	9.72	1.12	090
43843		A	Gastroplasty w/o v-band	21.08	NA	10.29	3.41	090
43845		A	Gastroplasty duodenal switch	33.12	NA	15.91	5.35	090
43846		A	Gastric bypass for obesity	27.23	NA	13.51	4.37	090
43847		A	Gastric bypass incl small i	30.10	NA	14.61	4.87	090
43848		A	Revision gastroplasty	32.57	NA	15.45	5.23	090
43850		A	Revise stomach-bowel fusion	27.45	NA	12.99	4.45	090
43855		A	Revise stomach-bowel fusion	28.56	NA	12.49	4.63	090
43860		A	Revise stomach-bowel fusion	27.76	NA	13.09	4.43	090
43865		A	Revise stomach-bowel fusion	28.92	NA	13.54	4.68	090
43870		A	Repair stomach opening	11.36	NA	6.35	1.78	090
43880		A	Repair stomach-bowel fistula	27.05	NA	12.76	4.27	090
43881		C	Implr/redo electrd, antrum	0.00	0.00	0.00	0.00	YYY
43882		C	Revise/remove electrd antrum	0.00	0.00	0.00	0.00	YYY
43886		A	Revise gastric port, open	4.54	NA	4.35	0.74	090
43887		A	Remove gastric port, open	4.24	NA	3.80	0.69	090
43888		A	Change gastric port, open	6.34	NA	5.02	1.03	090
43999		C	Stomach surgery procedure	0.00	0.00	0.00	0.00	YYY
44005		A	Freeing of bowel adhesion	18.38	NA	8.92	2.88	090
44010		A	Incision of small bowel	14.18	NA	7.33	2.26	090
44015		A	Insert needle cath bowel	2.62	NA	0.95	0.42	ZZZ
44020		A	Explore small intestine	16.14	NA	8.06	2.54	090
44021		A	Decompress small bowel	16.23	NA	8.11	2.57	090
44025		A	Incision of large bowel	16.43	NA	8.23	2.54	090
44050		A	Reduce bowel obstruction	15.44	NA	7.86	2.45	090

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44055		A	Correct malrotation of bowel	25.53	NA	11.70	4.06	090
44100		A	Biopsy of bowel	2.01	NA	0.88	0.15	000
44110		A	Excise intestine lesion(s)	13.96	NA	7.26	2.11	090
44111		A	Excision of bowel lesion(s)	16.44	NA	8.21	2.52	090
44120		A	Removal of small intestine	20.74	NA	9.80	3.24	090
44121		A	Removal of small intestine	4.44	NA	1.64	0.68	ZZZ
44125		A	Removal of small intestine	19.93	NA	9.63	3.05	090
44126		A	Enterectomy w/o taper, cong	42.02	NA	19.23	6.80	090
44127		A	Enterectomy w/taper, cong	49.09	NA	21.77	7.95	090
44128		A	Enterectomy cong, add-on	4.44	NA	1.65	0.72	ZZZ
44130		A	Bowel to bowel fusion	21.98	NA	10.77	3.42	090
44132		R	Enterectomy, cadaver donor	0.00	0.00	0.00	0.00	XXX
44133		R	Enterectomy, live donor	0.00	0.00	0.00	0.00	XXX
44135		R	Intestine transplnt, cadaver	0.00	0.00	0.00	0.00	XXX
44136		R	Intestine transplant, live	0.00	0.00	0.00	0.00	XXX
44137		C	Remove intestinal allograft	0.00	0.00	0.00	0.00	XXX
44139		A	Mobilization of colon	2.23	NA	0.83	0.34	ZZZ
44140		A	Partial removal of colon	22.46	NA	11.04	3.48	090
44141		A	Partial removal of colon	29.75	NA	15.84	4.61	090
44143		A	Partial removal of colon	27.63	NA	13.94	4.31	090
44144		A	Partial removal of colon	29.75	NA	14.49	4.64	090
44145		A	Partial removal of colon	28.45	NA	13.26	4.20	090
44146		A	Partial removal of colon	35.14	NA	18.21	5.11	090
44147		A	Partial removal of colon	33.56	NA	15.09	5.09	090
44150		A	Removal of colon	29.99	NA	16.86	4.61	090
44151		A	Removal of colon/ileostomy	34.73	NA	18.52	5.62	090
44155		A	Removal of colon/ileostomy	34.23	NA	18.31	4.89	090
44156		A	Removal of colon/ileostomy	37.23	NA	20.24	6.03	090
44157		A	Colectomy w/ileoanal anast	35.49	NA	18.96	5.75	090
44158		A	Colectomy w/neo-rectum pouch	36.49	NA	19.01	5.91	090
44160		A	Removal of colon	20.78	NA	10.30	3.21	090
44180		A	Lap, enterolysis	15.19	NA	7.74	2.37	090
44186		A	Lap, jejunostomy	10.30	NA	5.88	1.67	090
44187		A	Lap, ileo/jejuno-stomy	17.27	NA	10.62	2.46	090
44188		A	Lap, colostomy	19.20	NA	11.53	2.87	090
44202		A	Lap, enterectomy	23.26	NA	11.41	3.64	090
44203		A	Lap resect s/intestine, addl	4.44	NA	1.65	0.72	ZZZ
44204		A	Laparo partial colectomy	26.29	NA	12.46	3.94	090
44205		A	Lap colectomy part w/ileum	22.86	NA	10.93	3.41	090
44206		A	Lap part colectomy w/stoma	29.63	NA	14.38	4.56	090
44207		A	L colectomy/coloproctostomy	31.79	NA	14.41	4.66	090
44208		A	L colectomy/coloproctostomy	33.86	NA	16.68	4.78	090

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44210		A	Laparo total proctocolectomy	29.88	NA	15.39	4.37	090
44211		A	Lap colectomy w/proctectomy	36.87	NA	19.21	5.97	090
44212		A	Laparo total proctocolectomy	34.37	NA	17.92	4.79	090
44213		A	Lap, mobil splenic fl add-on	3.50	NA	1.30	0.51	ZZZ
44227		A	Lap, close enterostomy	28.49	NA	13.43	4.40	090
44238		C	Laparoscope proc, intestine	0.00	0.00	0.00	0.00	YYY
44300		A	Open bowel to skin	13.65	NA	7.30	2.18	090
44310		A	Ileostomy/jejunostomy	17.49	NA	8.74	2.56	090
44312		A	Revision of ileostomy	9.33	NA	5.51	1.31	090
44314		A	Revision of ileostomy	16.61	NA	8.73	2.36	090
44316		A	Devise bowel pouch	23.46	NA	11.63	3.80	090
44320		A	Colostomy	19.75	NA	10.23	3.00	090
44322		A	Colostomy with biopsies	13.15	NA	11.58	2.13	090
44340		A	Revision of colostomy	9.12	NA	6.34	1.39	090
44345		A	Revision of colostomy	17.06	NA	9.24	2.54	090
44346		A	Revision of colostomy	19.47	NA	10.20	2.92	090
44360		A	Small bowel endoscopy	2.59	NA	1.41	0.18	000
44361		A	Small bowel endoscopy/biopsy	2.87	NA	1.54	0.20	000
44363		A	Small bowel endoscopy	3.49	NA	1.77	0.25	000
44364		A	Small bowel endoscopy	3.73	NA	1.90	0.27	000
44365		A	Small bowel endoscopy	3.31	NA	1.72	0.24	000
44366		A	Small bowel endoscopy	4.40	NA	2.21	0.30	000
44369		A	Small bowel endoscopy	4.51	NA	2.26	0.31	000
44370		A	Small bowel endoscopy/stent	4.79	NA	2.54	0.32	000
44372		A	Small bowel endoscopy	4.40	NA	2.13	0.38	000
44373		A	Small bowel endoscopy	3.49	NA	1.76	0.28	000
44376		A	Small bowel endoscopy	5.25	NA	2.50	0.45	000
44377		A	Small bowel endoscopy/biopsy	5.52	NA	2.68	0.40	000
44378		A	Small bowel endoscopy	7.12	NA	3.39	0.49	000
44379		A	S bowel endoscope w/stent	7.46	NA	3.73	0.50	000
44380		A	Small bowel endoscopy	1.05	NA	0.70	0.08	000
44382		A	Small bowel endoscopy	1.27	NA	0.82	0.10	000
44383		A	Ileoscopy w/stent	2.94	NA	1.35	0.22	000
44385		A	Endoscopy of bowel pouch	1.82	4.62	0.94	0.18	000
44386		A	Endoscopy, bowel pouch/biop	2.12	6.51	1.14	0.20	000
44388		A	Colonoscopy	2.82	5.93	1.44	0.28	000
44389		A	Colonoscopy with biopsy	3.13	6.67	1.60	0.26	000
44390		A	Colonoscopy for foreign body	3.82	7.72	1.97	0.26	000
44391		A	Colonoscopy for bleeding	4.31	7.99	2.10	0.33	000
44392		A	Colonoscopy & polypectomy	3.81	7.16	1.83	0.36	000
44393		A	Colonoscopy, lesion removal	4.83	7.75	2.30	0.43	000
44394		A	Colonoscopy w/snare	4.42	8.01	2.14	0.39	000

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
44397		A	Colonoscopy w/stent	4.70	NA	2.34	0.32	000
44500		A	Intro, gastrointestinal tube	0.49	NA	0.16	0.04	000
44602		A	Suture, small intestine	24.64	NA	10.64	3.80	090
44603		A	Suture, small intestine	28.03	NA	12.46	4.25	090
44604		A	Suture, large intestine	18.06	NA	8.32	2.71	090
44605		A	Repair of bowel lesion	22.00	NA	10.76	3.43	090
44615		A	Intestinal stricturoplasty	18.08	NA	8.85	2.80	090
44620		A	Repair bowel opening	14.35	NA	7.46	2.12	090
44625		A	Repair bowel opening	17.20	NA	8.52	2.51	090
44626		A	Repair bowel opening	27.82	NA	12.49	4.30	090
44640		A	Repair bowel-skin fistula	24.12	NA	11.06	3.68	090
44650		A	Repair bowel fistula	25.04	NA	11.35	3.79	090
44660		A	Repair bowel-bladder fistula	23.83	NA	10.27	2.87	090
44661		A	Repair bowel-bladder fistula	27.27	NA	12.01	3.83	090
44680		A	Surgical revision, intestine	17.88	NA	8.90	2.90	090
44700		A	Suspend bowel w/prosthesis	17.40	NA	8.52	2.11	090
44701		A	Intraop colon lavage add-on	3.10	NA	1.15	0.43	ZZZ
44715		C	Prepare donor intestine	0.00	0.00	0.00	0.00	XXX
44720		A	Prep donor intestine/venous	5.00	NA	1.82	0.27	XXX
44721		A	Prep donor intestine/artery	7.00	NA	2.60	1.13	XXX
44799		C	Unlisted procedure intestine	0.00	0.00	0.00	0.00	YYY
44800		A	Excision of bowel pouch	11.94	NA	7.04	1.81	090
44820		A	Excision of mesentery lesion	13.63	NA	7.27	2.11	090
44850		A	Repair of mesentery	12.03	NA	6.46	1.90	090
44899		C	Bowel surgery procedure	0.00	0.00	0.00	0.00	YYY
44900		A	Drain app abscess, open	12.44	NA	6.73	1.98	090
44901		A	Drain app abscess, percut	3.37	14.70	1.03	0.28	000
44950		A	Appendectomy	10.52	NA	5.43	1.68	090
44955		A	Appendectomy add-on	1.53	NA	0.57	0.21	ZZZ
44960		A	Appendectomy	14.39	NA	7.31	2.30	090
44970		A	Laparoscopy, appendectomy	9.35	NA	5.52	1.49	090
44979		C	Laparoscope proc, app	0.00	0.00	0.00	0.00	YYY
45000		A	Drainage of pelvic abscess	6.20	NA	4.36	0.81	090
45005		A	Drainage of rectal abscess	2.00	4.56	1.93	0.26	010
45020		A	Drainage of rectal abscess	8.43	NA	5.65	1.21	090
45100		A	Biopsy of rectum	3.96	NA	3.47	0.54	090
45108		A	Removal of anorectal lesion	5.04	NA	4.04	0.82	090
45110		A	Removal of rectum	30.57	NA	16.19	4.39	090
45111		A	Partial removal of rectum	17.89	NA	9.46	2.66	090
45112		A	Removal of rectum	33.05	NA	14.84	4.59	090
45113		A	Partial proctectomy	33.09	NA	16.67	5.36	090
45114		A	Partial removal of rectum	30.63	NA	14.49	4.96	090
45116		A	Partial removal of rectum	27.56	NA	12.92	2.99	090
45119		A	Remove rectum w/reservoir	33.35	NA	16.54	4.42	090
45120		A	Removal of rectum	26.25	NA	13.22	4.25	090
45121		A	Removal of rectum and colon	28.93	NA	14.21	4.69	090
45123		A	Partial proctectomy	18.70	NA	9.78	2.38	090
45126		A	Pelvic exenteration	48.89	NA	22.21	7.92	090
45130		A	Excision of rectal prolapse	18.37	NA	9.47	2.34	090
45135		A	Excision of rectal prolapse	22.15	NA	11.91	3.59	090
45136		A	Excise ileoanal reservoir	30.63	NA	16.83	4.96	090
45150		A	Excision of rectal stricture	5.77	NA	4.21	0.63	090
45160		A	Excision of rectal lesion	16.17	NA	8.99	2.21	090
45170		A	Excision of rectal lesion	12.48	NA	7.23	1.75	090
45190		A	Destruction, rectal tumor	10.29	NA	7.08	1.42	090
45300		A	Proctosigmoidoscopy dx	0.80	2.25	0.59	0.10	000
45303		A	Proctosigmoidoscopy dilate	1.50	21.59	0.85	0.19	000
45305		A	Proctosigmoidoscopy w/bx	1.25	3.53	0.76	0.15	000
45307		A	Proctosigmoidoscopy fb	1.70	3.78	0.92	0.23	000
45308		A	Proctosigmoidoscopy removal	1.40	3.82	0.82	0.18	000
45309		A	Proctosigmoidoscopy removal	1.50	3.89	0.86	0.19	000
45315		A	Proctosigmoidoscopy removal	1.80	4.25	0.98	0.23	000
45317		A	Proctosigmoidoscopy bleed	2.00	3.84	1.04	0.24	000
45320		A	Proctosigmoidoscopy ablate	1.78	3.68	0.97	0.22	000
45321		A	Proctosigmoidoscopy volvul	1.75	NA	0.97	0.22	000
45327		A	Proctosigmoidoscopy w/stent	2.00	NA	1.16	0.32	000
45330		A	Diagnostic sigmoidoscopy	0.96	2.48	0.66	0.09	000
45331		A	Sigmoidoscopy and biopsy	1.15	3.00	0.77	0.09	000
45332		A	Sigmoidoscopy w/fb removal	1.79	5.27	1.02	0.16	000
45333		A	Sigmoidoscopy & polypectomy	1.79	5.40	1.02	0.16	000
45334		A	Sigmoidoscopy for bleeding	2.73	NA	1.46	0.20	000
45335		A	Sigmoidoscopy w/submuc inj	1.46	4.93	0.89	0.13	000
45337		A	Sigmoidoscopy & decompress	2.36	NA	1.27	0.21	000
45338		A	Sigmoidoscopy w/tumr remove	2.34	5.44	1.27	0.19	000
45339		A	Sigmoidoscopy w/ablate tumr	3.14	5.25	1.62	0.25	000
45340		A	Sig w/balloon dilation	1.89	9.65	1.06	0.18	000
45341		A	Sigmoidoscopy w/ultrasound	2.60	NA	1.40	0.19	000
45342		A	Sigmoidoscopy w/us guide bx	4.05	NA	2.05	0.28	000
45345		A	Sigmoidoscopy w/stent	2.92	NA	1.53	0.23	000
45355		A	Surgical colonoscopy	3.51	NA	1.71	0.34	000
45378		A	Diagnostic colonoscopy	3.69	6.00	1.84	0.31	000
45378		A	Diagnostic colonoscopy	0.96	2.48	0.66	0.08	000
45379	53	A	Colonoscopy w/fb removal	4.68	7.74	2.26	0.39	000
45380		A	Colonoscopy and biopsy	4.43	7.10	2.19	0.33	000

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CPT[1]/HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
45381		A	Colonoscopy, submucous inj	4.19	7.00	2.09	0.31	000
45382		A	Colonoscopy/control bleeding	5.68	9.28	2.75	0.41	000
45383		A	Lesion removal colonoscopy	5.86	8.20	2.73	0.51	000
45384		A	Lesion remove colonoscopy	4.69	6.87	2.25	0.41	000
45385		A	Lesion removal colonoscopy	5.30	7.72	2.56	0.41	000
45386		A	Colonoscopy dilate stricture	4.57	11.46	2.20	0.40	000
45387		A	Colonoscopy w/stent	5.90	NA	2.93	0.47	000
45391		A	Colonoscopy w/endoscope us	5.09	NA	2.48	0.37	000
45392		A	Colonoscopy w/endoscopic fnb	6.54	NA	3.10	0.50	000
45395		A	Lap, removal of rectum	32.79	NA	17.80	4.44	090
45397		A	Lap, remove rectum w/pouch	36.29	NA	18.84	4.54	090
45400		A	Laparoscopic proc	19.31	NA	9.90	2.68	090
45402		A	Lap proctopexy w/sig resect	26.38	NA	12.57	3.61	090
45499		C	Laparoscope proc, rectum	0.00	0.00	0.00	0.00	YYY
45500		A	Repair of rectum	7.64	NA	5.64	0.90	090
45505		A	Repair of rectum	8.20	NA	6.49	1.12	090
45520		A	Treatment of rectal prolapse	0.55	3.28	0.49	0.06	000
45540		A	Correct rectal prolapse	18.02	NA	8.91	2.34	090
45541		A	Correct rectal prolapse	14.72	NA	8.78	1.93	090
45550		A	Repair rectum/remove sigmoid	24.67	NA	12.59	3.34	090
45560		A	Repair of rectocele	11.42	NA	6.32	1.33	090
45562		A	Exploration/repair of rectum	17.82	NA	10.09	2.51	090
45563		A	Exploration/repair of rectum	26.22	NA	14.61	4.25	090
45800		A	Repair rect/bladder fistula	20.18	NA	9.99	2.54	090
45805		A	Repair fistula w/colostomy	23.19	NA	13.04	3.76	090
45820		A	Repair rectourethral fistula	20.24	NA	9.01	1.47	090
45825		A	Repair fistula w/colostomy	24.01	NA	13.79	2.61	090
45900		A	Reduction of rectal prolapse	2.96	NA	2.10	0.40	010
45905		A	Dilation of anal sphincter	2.32	NA	1.91	0.30	010
45910		A	Dilation of rectal narrowing	2.82	NA	2.07	0.34	010
45915		A	Remove rectal obstruction	3.16	4.82	2.45	0.32	010
45990		A	Surg dx exam, anorectal	1.80	NA	0.94	0.24	000
45999		C	Rectum surgery procedure	0.00	0.00	0.00	0.00	YYY
46020		A	Placement of seton	2.94	3.88	2.88	0.40	010
46030		A	Removal of rectal marker	1.24	2.20	1.02	0.16	010
46040		A	Incision of rectal abscess	5.26	7.78	4.92	0.78	090
46045		A	Incision of rectal abscess	5.79	NA	4.94	0.87	090
46050		A	Incision of anal abscess	1.21	3.72	1.21	0.16	010
46060		A	Incision of rectal abscess	6.24	NA	5.54	0.87	090
46070		A	Incision of anal septum	2.74	NA	2.85	0.15	090
46080		A	Incision of anal sphincter	2.59	3.66	1.49	0.36	010
46083		A	Incise external hemorrhoid	1.42	2.83	1.23	0.14	010
46200		A	Removal of anal fissure	3.48	7.36	4.51	0.46	090
46210		A	Removal of anal crypt	2.73	7.12	4.12	0.44	090
46211		A	Removal of anal crypts	4.31	8.32	4.94	0.70	090
46220		A	Removal of anal tag	1.58	3.49	1.37	0.21	010
46221		A	Ligation of hemorrhoid(s)	2.31	4.32	2.42	0.30	010
46230		A	Removal of anal tags	2.59	4.19	1.75	0.35	010
46250		A	Hemorrhoidectomy	4.17	7.12	3.58	0.61	090
46255		A	Hemorrhoidectomy	4.88	7.54	3.87	0.72	090
46257		A	Remove hemorrhoids & fissure	5.68	NA	4.85	0.79	090
46258		A	Remove hemorrhoids & fistula	6.28	NA	5.23	1.02	090
46260		A	Hemorrhoidectomy	6.65	NA	5.17	0.95	090
46261		A	Remove hemorrhoids & fissure	7.63	NA	5.57	1.03	090
46262		A	Remove hemorrhoids & fistula	7.80	NA	6.01	1.07	090
46270		A	Removal of anal fistula	4.81	7.60	4.82	0.72	090
46275		A	Removal of anal fistula	5.31	7.92	4.96	0.72	090
46280		A	Removal of anal fistula	6.28	NA	5.39	0.83	090
46285		A	Removal of anal fistula	5.31	7.85	4.97	0.68	090
46288		A	Repair anal fistula	7.68	NA	6.01	1.00	090
46320		A	Removal of hemorrhoid clot	1.62	2.90	1.15	0.20	010
46500		A	Injection into hemorrhoid(s)	1.64	4.19	1.57	0.20	010
46505		A	Chemodenervation anal musc	3.13	3.98	2.86	0.41	010
46600		A	Diagnostic anoscopy	0.55	1.61	0.49	0.06	000
46604		A	Anoscopy and dilation	1.03	13.88	0.67	0.12	000
46606		A	Anoscopy and biopsy	1.20	4.32	0.74	0.15	000
46608		A	Anoscopy, remove for body	1.30	4.42	0.71	0.16	000
46610		A	Anoscopy, remove lesion	1.28	4.29	0.78	0.17	000
46611		A	Anoscopy	1.30	2.97	0.77	0.13	000
46612		A	Anoscopy, remove lesions	1.50	5.01	0.87	0.19	000
46614		A	Anoscopy, control bleeding	1.00	2.17	0.66	0.11	000
46615		A	Anoscopy	1.50	2.03	0.84	0.19	000
46700		A	Repair of anal stricture	9.68	NA	6.78	1.23	090
46705		A	Repair of anal stricture	7.32	NA	5.24	0.39	090
46706		A	Repr of anal fistula w/glue	2.41	NA	1.82	0.32	010
46710		A	Repr per/vag pouch sngl proc	17.01	NA	10.31	2.75	090
46712		A	Repr per/vag pouch dbl proc	36.32	NA	17.34	1.95	090
46715		A	Rep perf anoper fistu	7.54	NA	4.93	0.40	090
46716		A	Rep perf anoper/vestib fistu	17.14	NA	13.18	1.84	090
46730		A	Construction of absent anus	30.17	NA	24.76	1.62	090
46735		A	Construction of absent anus	35.66	NA	18.01	1.91	090
46740		A	Construction of absent anus	33.42	NA	19.27	5.41	090
46742		A	Repair of imperforated anus	39.66	NA	21.26	2.12	090
46744		A	Repair of cloacal anomaly	58.46	NA	27.68	6.34	090

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46746		A	Repair of cloacal anomaly	64.93	NA	28.81	3.48	090
46748		A	Repair of cloacal anomaly	70.91	NA	30.99	3.80	090
46750		A	Repair of anal sphincter	12.02	NA	7.31	1.47	090
46751		A	Repair of anal sphincter	9.19	NA	5.69	1.18	090
46753		A	Reconstruction of anus	8.81	NA	5.94	1.09	090
46754		A	Removal of suture from anus	2.88	4.35	2.79	0.20	010
46760		A	Repair of anal sphincter	17.21	NA	10.67	1.87	090
46761		A	Repair of anal sphincter	15.16	NA	8.67	1.79	090
46762		A	Implant artificial sphincter	14.66	NA	8.93	1.59	090
46900		A	Destruction, anal lesion(s)	1.91	4.11	1.62	0.20	010
46910		A	Destruction, anal lesion(s)	1.88	4.40	1.50	0.23	010
46916		A	Cryosurgery, anal lesion(s)	1.88	3.84	1.78	0.12	010
46917		A	Laser surgery, anal lesions	1.88	9.31	1.45	0.22	010
46922		A	Excision of anal lesion(s)	1.88	4.71	1.50	0.26	010
46924		A	Destruction, anal lesion(s)	2.78	10.45	1.91	0.31	010
46930		A	Destroy internal hemorrhoids	1.56	3.33	2.01	0.17	090
46937		A	Cryotherapy of rectal lesion	2.70	3.60	1.72	0.18	010
46938		A	Cryotherapy of rectal lesion	4.70	7.07	4.59	0.76	090
46940		A	Treatment of anal fissure	2.33	3.39	1.41	0.26	010
46942		A	Treatment of anal fissure	2.05	3.36	1.30	0.24	010
46945		A	Ligation of hemorrhoids	2.13	5.33	3.37	0.28	090
46946		A	Ligation of hemorrhoids	2.60	5.01	2.96	0.32	090
46947		A	Hemorrhoidopexy by stapling	5.49	NA	4.01	0.81	090
46999		C	Anus surgery procedure	0.00	0.00	0.00	0.00	YYY
47000		A	Needle biopsy of liver	1.90	4.89	0.60	0.14	000
47001		A	Needle biopsy, liver add-on	1.90	NA	0.70	0.30	ZZZ
47010		A	Open drainage, liver lesion	19.27	NA	10.49	2.96	090
47011		A	Percut drain, liver lesion	3.69	NA	1.12	0.27	000
47015		A	Inject/aspirate liver cyst	18.37	NA	10.43	2.97	090
47100		A	Wedge biopsy of liver	12.78	NA	8.14	2.01	090
47120		A	Partial removal of liver	38.82	NA	19.08	6.21	090
47122		A	Extensive removal of liver	59.35	NA	26.16	9.57	090
47125		A	Partial removal of liver	52.91	NA	23.73	8.49	090
47130		A	Partial removal of liver	57.06	NA	25.10	9.13	090
47135		R	Transplantation of liver	83.29	NA	38.29	13.37	090
47136		R	Transplantation of liver	70.39	NA	33.74	11.40	090
47140		A	Partial removal, donor liver	59.22	NA	29.48	9.59	090
47141		A	Partial removal, donor liver	71.27	NA	32.10	3.82	090
47142		A	Partial removal, donor liver	79.21	NA	37.67	12.83	090
47143		C	Prep donor liver, whole	0.00	0.00	0.00	0.00	XXX
47144		C	Prep donor liver, 3-segment	0.00	0.00	0.00	0.00	090
47145		C	Prep donor liver, lobe split	0.00	0.00	0.00	0.00	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
47146		A	Prep donor liver/venous	6.00	NA	2.23	0.97	XXX
47147		A	Prep donor liver/arterial	7.00	NA	2.60	1.13	XXX
47300		A	Surgery for liver lesion	18.01	NA	10.19	2.91	090
47350		A	Repair liver wound	22.36	NA	11.73	3.52	090
47360		A	Repair liver wound	31.18	NA	14.95	5.05	090
47361		A	Repair liver wound	52.47	NA	22.84	8.04	090
47362		A	Repair liver wound	23.41	NA	12.43	3.73	090
47370		A	Laparo ablate liver tumor rf	20.67	NA	10.16	3.18	090
47371		A	Laparo ablate liver cryosurg	20.67	NA	10.46	3.35	090
47379		C	Laparoscope procedure, liver	0.00	0.00	0.00	0.00	YYY
47380		A	Open ablate liver tumor rf	24.43	NA	11.44	3.72	090
47381		A	Open ablate liver tumor cryo	24.72	NA	11.97	4.00	090
47382		A	Percut ablate liver rf	15.19	NA	5.06	1.14	010
47399		C	Liver surgery procedure	0.00	0.00	0.00	0.00	YYY
47400		A	Incision of liver duct	36.23	NA	17.31	5.87	090
47420		A	Incision of bile duct	21.92	NA	11.43	3.53	090
47425		A	Incision of bile duct	22.20	NA	11.72	3.60	090
47460		A	Incise bile duct sphincter	20.41	NA	11.05	3.31	090
47480		A	Incision of gallbladder	13.12	NA	8.45	2.07	090
47490		A	Incision of gallbladder	8.05	NA	4.63	0.59	090
47500		A	Injection for liver x-rays	1.96	NA	0.59	0.15	000
47505		A	Injection for liver x-rays	0.76	NA	0.23	0.06	000
47510		A	Insert catheter, bile duct	7.94	NA	4.04	0.61	090
47511		A	Insert bile duct drain	10.74	NA	4.28	0.79	090
47525		A	Change bile duct catheter	1.54	8.39	0.68	0.11	000
47530		A	Revise/reinsert bile tube	5.96	20.71	3.01	0.46	090
47550		A	Bile duct endoscopy add-on	3.02	NA	1.13	0.47	ZZZ
47552		A	Biliary endoscopy thru skin	6.03	NA	2.19	0.47	000
47553		A	Biliary endoscopy thru skin	6.34	NA	1.93	0.47	000
47554		A	Biliary endoscopy thru skin	9.05	NA	3.44	1.15	000
47555		A	Biliary endoscopy thru skin	7.55	NA	2.22	0.56	000
47556		A	Biliary endoscopy thru skin	8.55	NA	2.55	0.62	000
47560		A	Laparoscopy w/cholangio	4.88	NA	1.81	0.79	000
47561		A	Laparo w/cholangio/biopsy	5.17	NA	2.18	0.84	000
47562		A	Laparoscopic cholecystectomy	11.63	NA	6.93	1.87	090
47563		A	Laparo cholecystectomy/graph	12.03	NA	6.76	1.94	090
47564		A	Laparo cholecystectomy/explr	14.21	NA	7.31	2.28	090
47570		A	Laparo cholecystoenterostomy	12.56	NA	6.76	2.03	090
47579		C	Laparoscope proc, biliary	0.00	0.00	0.00	0.00	YYY
47600		A	Removal of gallbladder	17.35	NA	9.58	2.78	090
47605		A	Removal of gallbladder	15.90	NA	8.52	2.56	090
47610		A	Removal of gallbladder	20.84	NA	10.40	3.36	090

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CPT-1/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
47612		A	Removal of gallbladder	21.13	NA	10.40	3.42	090
47620		A	Removal of gallbladder	22.99	NA	11.12	3.72	090
47630		A	Remove bile duct stone	9.57	NA	4.40	0.91	090
47700		A	Exploration of bile ducts	16.39	NA	9.68	2.65	090
47701		A	Bile duct revision	28.62	NA	14.47	4.63	090
47711		A	Excision of bile duct tumor	25.77	NA	12.90	4.15	090
47712		A	Excision of bile duct tumor	33.59	NA	16.08	5.44	090
47715		A	Excision of bile duct cyst	21.42	NA	11.56	3.47	090
47720		A	Fuse gallbladder & bowel	18.21	NA	10.37	2.94	090
47721		A	Fuse upper gi structures	21.86	NA	11.72	3.54	090
47740		A	Fuse gallbladder & bowel	21.10	NA	11.44	3.42	090
47741		A	Fuse gallbladder & bowel	24.08	NA	12.55	3.90	090
47760		A	Fuse bile ducts and bowel	38.14	NA	17.92	6.11	090
47765		A	Fuse liver ducts & bowel	52.01	NA	23.55	8.42	090
47780		A	Fuse bile ducts and bowel	42.14	NA	19.43	6.80	090
47785		A	Fuse bile ducts and bowel	56.01	NA	24.87	9.08	090
47800		A	Reconstruction of bile ducts	26.04	NA	13.17	4.19	090
47801		A	Placement, bile duct support	17.47	NA	8.22	1.84	090
47802		A	Fuse liver duct & intestine	24.80	NA	13.07	4.02	090
47900		A	Suture bile duct injury	22.31	NA	11.72	3.55	090
47999		C	Bile tract surgery procedure	0.00	0.00	0.00	0.00	YYY
48000		A	Drainage of abdomen	31.82	NA	14.35	5.15	090
48001		A	Placement of drain, pancreas	39.56	NA	17.86	6.41	090
48020		A	Removal of pancreatic stone	18.96	NA	10.21	3.07	090
48100		A	Biopsy of pancreas, open	14.38	NA	7.65	2.26	090
48102		A	Needle biopsy, pancreas	4.68	6.26	1.62	0.35	010
48105		A	Resect/debride pancreas	49.05	NA	22.01	7.85	090
48120		A	Removal of pancreas lesion	18.33	NA	9.22	2.96	090
48140		A	Partial removal of pancreas	26.19	NA	12.67	4.20	090
48145		A	Partial removal of pancreas	27.26	NA	13.29	4.41	090
48146		A	Pancreatectomy	30.42	NA	16.19	4.93	090
48148		A	Removal of pancreatic duct	20.26	NA	10.69	3.28	090
48150		A	Partial removal of pancreas	52.63	NA	24.62	8.50	090
48152		A	Pancreatectomy	48.47	NA	23.27	7.85	090
48153		A	Pancreatectomy	52.61	NA	24.56	8.49	090
48154		A	Pancreatectomy	48.70	NA	23.36	7.89	090
48155		A	Removal of pancreas	29.27	NA	15.68	4.74	090
48400		A	Injection, intraop add-on	1.95	NA	0.87	0.13	ZZZ
48500		A	Surgery of pancreatic cyst	18.03	NA	10.48	2.92	090
48510		A	Drain pancreatic pseudocyst	17.06	NA	9.87	2.70	090
48511		A	Drain pancreatic pseudocyst	3.99	14.77	1.20	0.30	000
48520		A	Fuse pancreas cyst and bowel	18.07	NA	9.14	2.90	090
48540		A	Fuse pancreas cyst and bowel	21.86	NA	10.71	3.54	090
48545		A	Pancreatorrhaphy	22.10	NA	11.26	3.58	090
48547		A	Duodenal exclusion	30.25	NA	14.29	4.90	090
48548		A	Fuse pancreas and bowel	27.96	NA	13.29	4.53	090
48551		C	Prep donor pancreas	0.00	0.00	0.00	0.00	XXX
48552		A	Prep donor pancreas/venous	4.30	NA	1.60	0.70	XXX
48554		R	Transpl allograft pancreas	37.03	NA	25.79	5.86	090
48556		A	Removal, allograft pancreas	19.24	NA	12.20	3.12	090
48999		C	Pancreas surgery procedure	0.00	0.00	0.00	0.00	YYY
49000		A	Exploration of abdomen	12.44	NA	6.72	1.92	090
49002		A	Reopening of abdomen	17.55	NA	8.56	2.73	090
49010		A	Exploration behind abdomen	15.98	NA	7.52	2.35	090
49020		A	Drain abdominal abscess	26.46	NA	13.11	4.05	090
49021		A	Drain abdominal abscess	3.37	14.36	1.02	0.25	000
49040		A	Drain, open, abdom abscess	16.41	NA	8.53	2.54	090
49041		A	Drain, percut, abdom abscess	3.99	14.52	1.20	0.29	000
49060		A	Drain, open, retrop abscess	18.42	NA	8.99	2.76	090
49061		A	Drain, percut, retroper absc	3.69	14.42	1.11	0.27	000
49062		A	Drain to peritoneal cavity	12.12	NA	6.19	1.83	090
49080		A	Puncture, peritoneal cavity	1.35	2.56	0.44	0.10	000
49081		A	Removal of abdominal fluid	1.26	2.84	0.47	0.10	000
49180		A	Biopsy, abdominal mass	1.73	2.25	0.52	0.13	000
49203		A	Exc abd tum 5 cm or less	20.00	NA	9.85	2.73	090
49204		A	Exc abd tum over 5 cm	26.00	NA	12.07	3.35	090
49205		A	Exc abd tum over 10 cm	30.00	NA	13.65	3.93	090
49215		A	Excise sacral spine tumor	37.66	NA	17.08	5.53	090
49220		A	Multiple surgery, abdomen	15.70	NA	8.37	2.54	090
49250		A	Excision of umbilicus	8.93	NA	5.48	1.24	090
49255		A	Removal of omentum	12.41	NA	7.16	1.72	090
49320		A	Diag laparo separate proc	5.09	NA	3.04	0.68	010
49321		A	Laparoscopy, biopsy	5.39	NA	3.23	0.79	010
49322		A	Laparoscopy, aspiration	5.96	NA	3.29	0.69	010
49323		A	Laparo drain lymphocele	10.13	NA	5.63	1.60	090
49324		A	Lap insertion perm ip cath	6.27	NA	3.57	0.99	010
49325		A	Lap revision perm ip cath	6.77	NA	3.73	1.09	010
49326		A	Lap w/omentopexy add-on	3.50	NA	1.27	0.55	ZZZ
49329		C	Laparo proc, abdm/per/oment	0.00	0.00	0.00	0.00	YYY
49400		A	Air injection into abdomen	1.88	2.41	0.60	0.17	000
49402		A	Remove foreign body, adbomen	14.01	NA	7.26	2.17	090
49419		A	Insrt abdom cath for chemotx	7.03	NA	4.03	0.64	090
49420		A	Insert abdom drain, temp	2.22	NA	1.19	0.23	000
49421		A	Insert abdom drain, perm	5.87	NA	3.71	0.87	090

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CPT[1,2]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
49422		A	Remove perm cannula/catheter	6.26	NA	3.31	0.94	010
49423		A	Exchange drainage catheter	1.46	9.07	0.46	0.11	000
49424		A	Assess cyst, contrast inject	0.76	2.87	0.26	0.06	000
49425		A	Insert abdomen-venous drain	12.13	NA	6.49	2.03	090
49426		A	Revise abdomen-venous shunt	10.33	NA	5.44	1.55	090
49427		A	Injection, abdominal shunt	0.89	NA	0.28	0.08	000
49428		A	Ligation of shunt	6.79	NA	3.86	1.10	010
49429		A	Removal of shunt	7.41	NA	3.63	1.19	010
49435		A	Insert subq exten to ip cath	2.25	NA	0.76	0.34	ZZZ
49436		A	Embedded ip cath exit-site	2.69	NA	1.96	0.43	010
49440		A	Place gastrostomy tube perc	4.18	18.61	1.68	0.35	010
49441		A	Place duod/jej tube perc	4.77	19.77	1.86	0.41	010
49442		A	Place cecostomy tube perc	4.00	16.27	1.66	0.29	010
49446		A	Change g-tube to g-j perc	3.31	17.74	1.00	0.24	000
49450		A	Replace g/c tube perc	1.36	13.68	0.43	0.10	000
49451		A	Replace duod/jej tube perc	1.84	14.26	0.57	0.15	000
49452		A	Replace g-j tube perc	2.86	17.08	0.87	0.21	000
49460		A	Fix g/colon tube w/device	0.96	15.17	0.31	0.08	000
49465		A	Fluoro exam of g/colon tube	0.62	2.45	0.19	0.04	000
49491		A	Rpr hern preemie reduc	12.42	NA	7.18	2.01	090
49492		A	Rpr ing hern premie, blocked	15.32	NA	6.62	2.48	090
49495		A	Rpr ing hernia baby, reduc	6.15	NA	3.99	1.00	090
49496		A	Rpr ing hernia baby, blocked	9.32	NA	5.82	1.66	090
49500		A	Rpr ing hernia, init, reduce	5.76	NA	4.37	0.93	090
49501		A	Rpr ing hernia, init blocked	9.28	NA	5.67	1.50	090
49505		A	Prp i/hern init reduc >5 yr	7.88	NA	5.00	1.25	090
49507		A	Prp i/hern init block >5 yr	9.97	NA	5.84	1.59	090
49520		A	Rerepair ing hernia, reduce	9.91	NA	5.74	1.59	090
49521		A	Rerepair ing hernia, blocked	12.36	NA	6.62	1.97	090
49525		A	Repair ing hernia, sliding	8.85	NA	5.34	1.40	090
49540		A	Repair lumbar hernia	10.66	NA	6.11	1.69	090
49550		A	Rpr rem hernia, init, reduce	8.91	NA	5.36	1.43	090
49553		A	Rpr fem hernia, init blocked	9.84	NA	5.81	1.58	090
49555		A	Rerepair fem hernia, reduce	9.31	NA	5.56	1.49	090
49557		A	Rerepair fem hernia, blocked	11.54	NA	6.43	1.85	090
49560		A	Rpr ventral hern init, reduc	11.84	NA	6.48	1.87	090
49561		A	Rpr ventral hern init, block	15.30	NA	7.81	2.44	090
49565		A	Rerepair ventrl hern, reduce	12.29	NA	6.78	1.96	090
49566		A	Rerepair ventrl hern, block	15.45	NA	7.90	2.48	090
49568		A	Hernia repair w/mesh	4.88	NA	1.81	0.78	ZZZ
49570		A	Rpr epigastric hern, reduce	5.97	NA	4.29	0.96	090
49572		A	Rpr epigastric hern, blocked	7.79	NA	4.95	1.25	090

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49580		A	Rpr umbil hern, reduc < 5 yr	4.39	NA	3.77	0.71	090
49582		A	Rpr umbil hern, block < 5 yr	7.05	NA	4.85	1.14	090
49585		A	Rpr umbil hern, reduc > 5 yr	6.51	NA	4.47	1.03	090
49587		A	Rpr umbil hern, block > 5 yr	7.96	NA	5.02	1.27	090
49590		A	Repair spigelian hernia	8.82	NA	5.33	1.41	090
49600		A	Repair umbilical lesion	11.47	NA	6.60	1.86	090
49605		A	Repair umbilical lesion	86.85	NA	35.93	14.06	090
49606		A	Repair umbilical lesion	18.92	NA	9.18	3.06	090
49610		A	Repair umbilical lesion	10.83	NA	6.18	0.58	090
49611		A	Repair umbilical lesion	9.26	NA	5.05	0.50	090
49650		A	Lap ing hernia repair init	6.30	NA	4.31	1.01	090
49651		A	Lap ing hernia repair recur	8.29	NA	5.49	1.33	090
49652		A	Lap vent/abd hernia repair	12.80	NA	7.01	0.69	090
49653		A	Lap vent/abd hern proc comp	16.10	NA	8.68	0.86	090
49654		A	Lap inc hernia repair	14.95	NA	7.81	0.80	090
49655		A	Lap inc hern repair comp	18.00	NA	9.38	0.96	090
49656		A	Lap inc hernia repair recur	15.00	NA	7.83	0.80	090
49657		A	Lap inc hern recur comp	22.00	NA	10.87	1.18	090
49659		C	Laparo proc, hernia repair	0.00	0.00	0.00	0.00	YYY
49900		A	Repair of abdominal wall	12.26	NA	7.98	1.88	090
49904		A	Omental flap, extra-abdom	22.16	NA	13.67	3.55	090
49905		A	Omental flap, intra-abdom	6.54	NA	2.39	0.92	ZZZ
49906		C	Free omental flap, microvasc	0.00	0.00	0.00	0.00	090
49999		C	Abdomen surgery procedure	0.00	0.00	0.00	0.00	YYY
50010		A	Exploration of kidney	12.13	NA	6.37	1.28	090
50020		A	Renal abscess, open drain	17.88	NA	9.00	1.80	090
50021		A	Renal abscess, percut drain	3.37	15.13	1.01	0.24	000
50040		A	Drainage of kidney	16.48	NA	7.33	1.26	090
50045		A	Exploration of kidney	16.67	NA	7.45	1.21	090
50060		A	Removal of kidney stone	20.80	NA	8.80	1.51	090
50065		A	Incision of kidney	22.17	NA	9.25	1.61	090
50070		A	Incision of kidney	21.70	NA	9.09	1.57	090
50075		A	Removal of kidney stone	26.91	NA	10.99	1.95	090
50080		A	Removal of kidney stone	15.61	NA	6.91	1.15	090
50081		A	Removal of kidney stone	23.32	NA	9.84	1.72	090
50100		A	Revise kidney blood vessels	17.30	NA	9.35	2.80	090
50120		A	Exploration of kidney	17.06	NA	7.52	1.24	090
50125		A	Explore and drain kidney	17.67	NA	9.49	1.28	090
50130		A	Removal of kidney stone	18.67	NA	8.10	1.35	090
50135		A	Exploration of kidney	20.44	NA	8.68	1.48	090
50200		A	Biopsy of kidney	2.63	NA	1.10	0.20	000
50205		A	Biopsy of kidney	12.19	NA	6.51	1.80	090

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5020F		I	Txmnts 2 main Dr by 1 mon	0.00	0.00	0.00	0.00	XXX
50220		A	Remove kidney, open	18.53	NA	8.28	1.64	090
50225		A	Removal kidney open, complex	21.73	NA	9.32	1.79	090
50230		A	Removal kidney open, radical	23.68	NA	9.63	1.83	090
50234		A	Removal of kidney & ureter	23.90	NA	9.90	1.82	090
50236		A	Removal of kidney & ureter	26.74	NA	11.33	1.96	090
50240		A	Partial removal of kidney	24.01	NA	10.31	1.80	090
50250		A	Cryoablate renal mass open	22.06	NA	9.64	1.61	090
50280		A	Removal of kidney lesion	16.94	NA	7.66	1.37	090
50290		A	Removal of kidney lesion	16.00	NA	7.23	1.16	090
50320		A	Remove kidney, living donor	22.28	NA	13.48	2.91	090
50323		C	Prep cadaver renal allograft	0.00	0.00	0.00	0.00	XXX
50325		C	Prep donor renal graft	0.00	0.00	0.00	0.00	XXX
50327		A	Prep renal graft/venous	4.00	NA	1.45	0.59	XXX
50328		A	Prep renal graft/arterial	3.50	NA	1.26	0.50	XXX
50329		A	Prep renal graft/ureteral	3.34	NA	1.14	0.34	XXX
50340		A	Removal of kidney	13.86	NA	9.48	2.24	090
50360		A	Transplantation of kidney	40.45	NA	23.23	6.22	090
50365		A	Transplantation of kidney	45.68	NA	24.93	7.40	090
50370		A	Remove transplanted kidney	18.68	NA	11.01	2.80	090
50380		A	Reimplantation of kidney	29.66	NA	19.55	4.80	090
50382		A	Change ureter stent, percut	5.50	18.91	1.71	0.40	000
50384		A	Remove ureter stent, percut	5.00	14.19	1.56	0.36	000
50385		A	Change stent via transureth	4.44	19.36	1.62	0.33	000
50386		A	Remove stent via transureth	3.30	12.29	1.30	0.24	000
50387		A	Change ext/int ureter stent	2.00	9.28	0.59	0.15	000
50389		A	Remove renal tube w/fluoro	1.10	5.58	0.33	0.08	000
50390		A	Drainage of kidney lesion	1.96	NA	0.59	0.14	000
50391		A	Instll rx agnt into rnal tub	1.96	1.27	0.69	0.14	000
50392		A	Insert kidney drain	3.37	NA	1.29	0.24	000
50393		A	Insert ureteral tube	4.15	NA	1.52	0.30	000
50394		A	Injection for kidney x-ray	0.76	1.70	0.51	0.06	000
50395		A	Create passage to kidney	3.37	NA	1.32	0.25	000
50396		A	Measure kidney pressure	2.09	NA	0.90	0.15	000
50398		A	Change kidney tube	1.46	8.22	0.47	0.11	000
50400		A	Revision of kidney/ureter	21.12	NA	8.93	1.56	090
50405		A	Revision of kidney/ureter	25.68	NA	10.59	1.86	090
50500		A	Repair of kidney wound	21.07	NA	10.30	3.41	090
50520		A	Close kidney-skin fistula	18.73	NA	8.12	1.36	090
50525		A	Repair renal-abdomen fistula	24.21	NA	12.12	3.92	090
50526		A	Repair renal-abdomen fistula	26.13	NA	11.84	1.40	090
50540		A	Revision of horseshoe kidney	20.95	NA	8.85	1.52	090

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
50541		A	Laparo ablate renal cyst	16.76	NA	7.18	1.27	090
50542		A	Laparo ablate renal mass	21.18	NA	9.13	1.56	090
50543		A	Laparo partial nephrectomy	27.18	NA	11.50	2.01	090
50544		A	Laparoscopy, pyeloplasty	23.27	NA	9.27	1.73	090
50545		A	Laparo radical nephrectomy	24.93	NA	10.04	1.88	090
50546		A	Laparoscopic nephrectomy	21.69	NA	9.41	1.70	090
50547		A	Laparo removal donor kidney	26.24	NA	14.00	3.63	090
50548		A	Laparo remove w/ureter	25.26	NA	9.95	1.87	090
50549		C	Laparoscope proc, renal	0.00	0.00	0.00	0.00	YYY
50551		A	Kidney endoscopy	5.59	3.64	2.16	0.41	000
50553		A	Kidney endoscopy	5.98	3.87	2.23	0.44	000
50555		A	Kidney endoscopy & biopsy	6.52	4.05	2.45	0.47	000
50557		A	Kidney endoscopy & treatment	6.61	4.15	2.49	0.48	000
50561		A	Kidney endoscopy & treatment	7.58	4.65	2.80	0.56	000
50562		A	Renal scope w/tumor resect	10.90	NA	4.34	0.79	090
50570		A	Kidney endoscopy	9.53	NA	3.41	0.69	000
50572		A	Kidney endoscopy	10.33	NA	3.67	0.75	000
50574		A	Kidney endoscopy & biopsy	11.00	NA	3.89	0.80	000
50575		A	Kidney endoscopy	13.96	NA	4.86	1.01	000
50576		A	Kidney endoscopy & treatment	10.97	NA	3.88	0.79	000
50580		A	Kidney endoscopy & treatment	11.84	NA	4.16	0.86	000
50590		A	Fragmenting of kidney stone	9.64	13.18	4.88	0.70	090
50592		A	Perc rf ablate renal tumor	6.77	62.27	2.60	0.49	010
50593		A	Perc cryo ablate renal tum	9.08	92.65	3.51	0.66	010
50600		A	Exploration of ureter	17.04	NA	7.32	1.23	090
50605		A	Insert ureteral support	16.66	NA	7.83	1.95	090
50610		A	Removal of ureter stone	17.12	NA	7.40	1.24	090
50620		A	Removal of ureter stone	16.30	NA	7.13	1.18	090
50630		A	Removal of ureter stone	16.08	NA	7.06	1.16	090
50650		A	Removal of ureter	18.67	NA	8.17	1.40	090
50660		A	Removal of ureter	20.87	NA	8.82	1.51	090
50684		A	Injection for ureter x-ray	0.76	3.38	0.52	0.06	000
50686		A	Measure ureter pressure	1.51	2.32	0.89	0.09	000
50688		A	Change of ureter tube/stent	1.18	NA	0.83	0.09	010
50690		A	Injection for ureter x-ray	1.16	1.26	0.64	0.08	000
50700		A	Revision of ureter	16.54	NA	7.64	1.20	090
50715		A	Release of ureter	20.49	NA	9.69	1.76	090
50722		A	Release of ureter	17.80	NA	8.70	2.28	090
50725		A	Release/revise ureter	20.05	NA	8.55	1.45	090
50727		A	Revise ureter	8.17	NA	4.71	0.63	090
50728		A	Revise ureter	12.00	NA	5.92	0.87	090
50740		A	Fusion of ureter & kidney	19.92	NA	10.33	3.23	090

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CPT[1,2]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
50750		A	Fusion of ureter & kidney	21.07	NA	8.89	1.53	090
50760		A	Fusion of ureters	19.92	NA	8.92	1.95	090
50770		A	Splicing of ureters	21.07	NA	8.89	1.53	090
50780		A	Reimplant ureter in bladder	19.80	NA	8.75	1.72	090
50782		A	Reimplant ureter in bladder	19.51	NA	8.38	3.16	090
50783		A	Reimplant ureter in bladder	20.52	NA	10.55	1.49	090
50785		A	Reimplant ureter in bladder	22.08	NA	9.35	1.66	090
50800		A	Implant ureter in bowel	16.23	NA	7.55	1.29	090
50810		A	Fusion of ureter & bowel	22.38	NA	12.10	3.62	090
50815		A	Urine shunt to intestine	22.06	NA	9.60	1.60	090
50820		A	Construct bowel bladder	23.89	NA	10.25	1.96	090
50825		A	Construct bowel bladder	30.48	NA	12.50	2.32	090
50830		A	Revise urine flow	33.57	NA	13.36	2.43	090
50840		A	Replace ureter by bowel	22.19	NA	9.64	1.61	090
50845		A	Appendico-vesicostomy	22.21	NA	10.04	1.61	090
50860		A	Transplant ureter to skin	16.93	NA	7.53	1.23	090
50900		A	Repair of ureter	14.89	NA	7.18	1.08	090
50920		A	Closure ureter/skin fistula	15.66	NA	7.12	1.13	090
50930		A	Closure ureter/bowel fistula	20.04	NA	8.55	3.25	090
50940		A	Release of ureter	15.78	NA	7.16	1.14	090
50945		A	Laparoscopy ureterolithotomy	17.87	NA	7.45	1.29	090
50947		A	Laparo new ureter/bladder	25.63	NA	10.38	1.86	090
50948		A	Laparo new ureter/bladder	23.69	NA	9.52	1.72	090
50949		C	Laparoscope proc, ureter	0.00	0.00	0.00	0.00	YYY
50951		A	Endoscopy of ureter	5.83	3.81	2.24	0.43	000
50953		A	Endoscopy of ureter	6.23	3.98	2.65	0.45	000
50955		A	Ureter endoscopy & biopsy	6.74	4.18	2.83	0.49	000
50957		A	Ureter endoscopy & treatment	6.78	4.25	2.55	0.49	000
50961		A	Ureter endoscopy & treatment	6.04	3.87	2.30	0.44	000
50970		A	Ureter endoscopy	7.13	NA	2.62	0.52	000
50972		A	Ureter endoscopy & catheter	6.88	NA	2.54	0.50	000
50974		A	Ureter endoscopy & biopsy	9.16	NA	3.29	0.66	000
50976		A	Ureter endoscopy & treatment	9.03	NA	3.25	0.65	000
50980		A	Ureter endoscopy & treatment	6.84	NA	2.53	0.50	000
5100F		I	Rsk fx ref w/n 24 hrs x-ray	0.00	0.00	0.00	0.00	XXX
51020		A	Incise & treat bladder	7.56	NA	4.39	0.58	090
51030		A	Incise & treat bladder	7.68	NA	4.02	0.56	090
51040		A	Incise & drain bladder	4.43	NA	2.94	0.33	090
51045		A	Incise bladder/drain ureter	7.68	NA	4.64	0.75	090
51050		A	Removal of bladder stone	7.87	NA	4.25	0.58	090
51060		A	Removal of ureter stone	9.82	NA	5.09	0.71	090
51065		A	Remove ureter calculus	9.82	NA	5.03	0.71	090

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CPT[1,2]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
51080		A	Drainage of bladder abscess	6.61	NA	3.83	0.48	090
51100		A	Drain bladder by needle	0.78	0.80	0.25	0.06	000
51101		A	Drain bladder by trocar/cath	1.02	2.13	0.36	0.08	000
51102		A	Drain bl w/cath insertion	2.70	3.01	1.10	0.20	000
51500		A	Removal of bladder cyst	10.92	NA	5.45	0.79	090
51520		A	Removal of bladder lesion	10.08	NA	5.18	0.73	090
51525		A	Removal of bladder lesion	15.29	NA	6.96	1.16	090
51530		A	Removal of bladder lesion	13.58	NA	6.56	1.17	090
51535		A	Repair of ureter lesion	13.77	NA	6.37	1.00	090
51550		A	Partial removal of bladder	17.10	NA	7.77	1.58	090
51555		A	Partial removal of bladder	23.03	NA	9.84	1.88	090
51565		A	Revise bladder & ureter(s)	23.50	NA	10.08	1.78	090
51570		A	Removal of bladder	27.31	NA	11.16	2.07	090
51575		A	Removal of bladder & nodes	34.00	NA	13.53	2.46	090
51580		A	Remove bladder/revise tract	35.14	NA	14.18	2.55	090
51585		A	Removal of bladder & nodes	39.41	NA	15.58	2.86	090
51590		A	Remove bladder/revise tract	36.15	NA	14.22	2.71	090
51595		A	Remove bladder/revise tract	41.12	NA	16.02	3.04	090
51596		A	Remove bladder/create pouch	44.01	NA	17.33	3.22	090
51597		A	Removal of pelvic structures	42.61	NA	17.07	3.33	090
51600		A	Injection for bladder x-ray	0.88	3.63	0.28	0.06	000
51605		A	Preparation for bladder xray	0.64	NA	0.36	0.05	000
51610		A	Injection for bladder x-ray	1.05	1.62	0.60	0.08	000
51700		A	Irrigation of bladder	0.88	1.20	0.30	0.06	000
51701		A	Insert bladder catheter	0.50	0.86	0.22	0.04	000
51702		A	Insert temp bladder cath	0.50	1.25	0.29	0.04	000
51703		A	Insert bladder cath, complex	1.47	1.80	0.67	0.11	000
51705		A	Change of bladder tube	1.03	1.59	0.68	0.08	010
51710		A	Change of bladder tube	1.50	2.13	0.94	0.11	010
51715		A	Endoscopic injection/implant	3.73	3.57	1.49	0.27	000
51720		A	Treatment of bladder lesion	1.50	1.28	0.61	0.11	000
51725		A	Simple cystometrogram	1.51	3.39	3.39	0.11	000
51725	TC	A	Simple cystometrogram	0.00	2.87	2.87	0.00	000
51725	26	A	Simple cystometrogram	1.51	0.52	0.52	0.10	000
51726		A	Complex cystometrogram	1.71	5.63	5.63	0.12	000
51726	TC	A	Complex cystometrogram	0.00	5.05	5.05	0.00	000
51726	26	A	Complex cystometrogram	1.71	0.59	0.59	0.12	000
51736		A	Urine flow measurement	0.61	0.73	0.73	0.04	000
51736	TC	A	Urine flow measurement	0.00	0.53	0.53	0.00	000
51736	26	A	Urine flow measurement	0.61	0.21	0.21	0.04	000
51741		A	Electro-uroflowmetry, first	1.14	1.00	1.00	0.08	000
51741	TC	A	Electro-uroflowmetry, first	0.00	0.62	0.62	0.00	000

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CPT[1],[3] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
51741	26	A	Electro-uroflowmetry, first	1.14	0.38	0.38	0.08	000
51772		A	Urethra pressure profile	1.61	4.27	4.27	0.11	000
51772	TC	A	Urethra pressure profile	0.00	3.70	3.70	0.00	000
51772	26	A	Urethra pressure profile	1.61	0.57	0.57	0.11	000
51784		A	Anal/urinary muscle study	1.53	3.35	3.35	0.11	000
51784	TC	A	Anal/urinary muscle study	0.00	2.83	2.83	0.00	000
51784	26	A	Anal/urinary muscle study	1.53	0.53	0.53	0.11	000
51785		A	Anal/urinary muscle study	1.53	3.83	3.83	0.11	000
51785	TC	A	Anal/urinary muscle study	0.00	3.30	3.30	0.00	000
51785	26	A	Anal/urinary muscle study	1.53	0.53	0.53	0.11	000
51792		A	Urinary reflex study	1.10	4.09	4.09	0.08	000
51792	TC	A	Urinary reflex study	0.00	3.71	3.71	0.00	000
51792	26	A	Urinary reflex study	1.10	0.38	0.38	0.08	000
51795		A	Urine voiding pressure study	1.53	5.35	5.35	0.11	000
51795	TC	A	Urine voiding pressure study	0.00	4.83	4.83	0.00	000
51795	26	A	Urine voiding pressure study	1.53	0.52	0.52	0.10	000
51797		A	Intraabdominal pressure test	0.80	1.96	1.96	0.06	ZZZ
51797	TC	A	Intraabdominal pressure test	0.00	1.69	1.69	0.00	ZZZ
51797	26	A	Intraabdominal pressure test	0.80	0.27	0.27	0.05	ZZZ
51798		A	Us urine capacity measure	0.00	0.44	NA	0.00	XXX
51800		A	Revision of bladder/urethra	18.74	NA	8.30	1.43	090
51820		A	Revision of urinary tract	19.41	NA	8.62	1.41	090
51840		A	Attach bladder/urethra	11.28	NA	5.73	1.08	090
51841		A	Attach bladder/urethra	13.60	NA	6.60	1.29	090
51845		A	Repair bladder neck	10.07	NA	5.08	0.89	090
51860		A	Repair of bladder wound	12.49	NA	6.49	1.36	090
51865		A	Repair of bladder wound	15.69	NA	7.37	1.43	090
51880		A	Repair of bladder opening	7.81	NA	4.21	0.70	090
51900		A	Repair bladder/vagina lesion	14.48	NA	7.08	1.05	090
51920		A	Close bladder-uterus fistula	13.26	NA	6.40	0.96	090
51925		A	Hysterectomy/bladder repair	17.35	NA	8.93	2.22	090
51940		A	Correction of bladder defect	30.48	NA	12.25	2.21	090
51960		A	Revision of bladder & bowel	25.20	NA	10.80	1.97	090
51980		A	Construct bladder opening	12.44	NA	5.95	0.90	090
51990		A	Laparo urethral suspension	13.26	NA	6.40	1.32	090
51992		A	Laparo sling operation	14.77	NA	7.02	1.66	090
51999		C	Laparoscope proc, bla	0.00	0.00	0.00	0.00	YYY
52000		A	Cystoscopy	2.23	2.84	1.05	0.16	000
52001		A	Cystoscopy, removal of clots	5.44	4.01	2.11	0.40	000
52005		A	Cystoscopy & ureter catheter	2.37	4.40	1.10	0.17	000
52007		A	Cystoscopy and biopsy	3.02	8.26	1.31	0.22	000
52010		A	Cystoscopy & duct catheter	3.02	6.22	1.31	0.22	000
52204		A	Cystoscopy w/biopsy(s)	2.59	6.37	1.11	0.19	000
52214		A	Cystoscopy and treatment	3.70	12.01	1.47	0.27	000
52224		A	Cystoscopy and treatment	3.14	11.41	1.29	0.23	000
52234		A	Cystoscopy and treatment	4.62	NA	1.83	0.34	000
52235		A	Cystoscopy and treatment	5.44	NA	2.13	0.40	000
52240		A	Cystoscopy and radiotracer	4.49	NA	1.88	0.32	000
52250		A	Cystoscopy and treatment	3.91	NA	1.60	0.28	000
52265		A	Cystoscopy and treatment	2.94	6.07	1.33	0.21	000
52270		A	Cystoscopy & revise urethra	3.36	5.40	1.40	0.24	000
52275		A	Cystoscopy & revise urethra	4.69	7.16	1.84	0.34	000
52276		A	Cystoscopy and treatment	4.99	NA	1.97	0.36	000
52277		A	Cystoscopy and treatment	6.16	NA	2.68	0.43	000
52281		A	Cystoscopy and treatment	2.80	4.08	1.24	0.20	000
52282		A	Cystoscopy, implant stent	6.39	NA	2.46	0.47	000
52283		A	Cystoscopy and treatment	3.73	3.27	1.56	0.28	000
52285		A	Cystoscopy and treatment	3.60	3.42	1.52	0.26	000
52290		A	Cystoscopy and treatment	4.58	NA	1.83	0.33	000
52300		A	Cystoscopy and treatment	5.30	NA	2.15	0.39	000
52301		A	Cystoscopy and treatment	5.50	NA	2.18	0.40	000
52305		A	Cystoscopy and treatment	5.30	NA	2.02	0.39	000
52310		A	Cystoscopy and treatment	2.81	3.12	1.16	0.21	000
52315		A	Cystoscopy and treatment	5.20	5.15	2.00	0.38	000
52317		A	Remove bladder stone	6.71	13.08	2.43	0.49	000
52318		A	Remove bladder stone	9.18	NA	3.28	0.67	000
52320		A	Cystoscopy and treatment	4.69	NA	1.79	0.34	000
52325		A	Cystoscopy, stone removal	6.15	NA	2.28	0.45	000
52327		A	Cystoscopy, inject material	5.18	NA	1.71	0.37	000
52330		A	Cystoscopy and treatment	5.03	7.19	1.90	0.37	000
52332		A	Cystoscopy and treatment	2.83	9.48	1.25	0.21	000
52334		A	Create passage to kidney	4.82	NA	1.90	0.35	000
52341		A	Cysto w/ureter stricture tx	5.20	NA	2.17	0.39	000
52342		A	Cysto w/up stricture tx	5.63	NA	2.30	0.43	000
52343		A	Cysto w/renal stricture tx	6.55	NA	2.61	0.47	000
52344		A	Cysto/uretero, stricture tx	6.83	NA	2.83	0.51	000
52345		A	Cysto/uretero w/up stricture	8.51	NA	3.38	0.55	000
52346		A	Cystouretero w/renal strict	9.02	NA	3.54	0.62	000
52351		A	Cystouretero & or pyeloscope	5.85	NA	2.38	0.43	000
52352		A	Cystouretero w/stone remove	6.87	NA	2.79	0.50	000
52353		A	Cystouretero w/lithotripsy	7.96	NA	3.15	0.58	000
52354		A	Cystouretero w/biopsy	7.33	NA	2.94	0.53	000
52355		A	Cystouretero w/excise tumor	8.81	NA	3.43	0.64	000

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CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
52400		A	Cystouretero w/congen repr	8.25	NA	3.65	0.63	090
52402		A	Cystourethro cut ejacul duct	5.27	NA	1.76	0.38	000
52450		A	Incision of prostate	7.63	NA	4.34	0.56	090
52500		A	Revision of bladder neck	8.49	NA	4.62	0.58	090
52601		A	Prostatectomy (TURP)	15.13	NA	6.76	1.11	090
52630		A	Remove prostate regrowth	7.65	NA	3.82	0.56	090
52640		A	Relieve bladder contracture	4.28	NA	2.66	0.34	090
52647		A	Laser surgery of prostate	11.15	31.99	5.49	0.81	090
52648		A	Laser surgery of prostate	12.00	32.48	5.77	0.88	090
52649		A	Prostate laser enucleation	17.16	NA	7.48	1.25	090
52700		A	Drainage of prostate abscess	7.39	NA	3.92	0.54	090
53000		A	Incision of urethra	2.30	NA	1.50	0.17	010
53010		A	Incision of urethra	4.35	NA	3.09	0.32	090
53020		A	Incision of urethra	1.77	NA	0.77	0.13	000
53025		A	Incision of urethra	1.13	NA	0.71	0.06	000
53040		A	Drainage of urethra abscess	6.49	NA	3.60	0.47	090
53060		A	Drainage of urethra abscess	2.65	2.01	1.58	0.17	010
53080		A	Drainage of urinary leakage	6.82	NA	3.92	0.49	090
53085		A	Drainage of urinary leakage	11.05	NA	5.42	1.09	090
53200		A	Biopsy of urethra	2.59	1.42	1.11	0.19	000
53210		A	Removal of urethra	13.59	NA	6.39	1.06	090
53215		A	Removal of urethra	16.72	NA	7.35	1.22	090
53220		A	Treatment of urethra lesion	7.53	NA	4.13	0.58	090
53230		A	Removal of urethra lesion	10.31	NA	5.27	0.86	090
53235		A	Removal of urethra lesion	10.86	NA	5.41	0.79	090
53240		A	Surgery for urethra pouch	6.98	NA	3.88	0.51	090
53250		A	Removal of urethra gland	6.42	NA	3.51	1.07	090
53260		A	Treatment of urethra lesion	3.00	2.12	1.63	0.21	010
53265		A	Treatment of urethra lesion	3.14	2.38	1.65	0.22	010
53270		A	Removal of urethra gland	3.11	2.23	1.75	0.20	010
53275		A	Repair of urethra defect	4.54	NA	2.24	0.33	010
53400		A	Revise urethra, stage 1	13.98	NA	6.67	1.04	090
53405		A	Revise urethra, stage 2	15.51	NA	7.06	1.12	090
53410		A	Reconstruction of urethra	17.53	NA	7.83	1.29	090
53415		A	Reconstruction of urethra	20.55	NA	8.85	1.55	090
53420		A	Reconstruct urethra, stage 1	15.04	NA	6.73	1.09	090
53425		A	Reconstruct urethra, stage 2	16.94	NA	7.35	1.23	090
53430		A	Reconstruction of urethra	17.30	NA	7.74	1.46	090
53431		A	Reconstruct urethra/bladder	21.03	NA	8.94	1.52	090
53440		A	Male sling procedure	15.34	NA	7.43	1.12	090
53442		A	Remove/revise male sling	13.29	NA	6.79	0.97	090
53444		A	Insert tandem cuff	14.06	NA	6.48	1.01	090
53445		A	Insert uro/ves neck sphincter	17.02	NA	7.98	1.11	090
53446		A	Remove uro sphincter	10.89	NA	5.63	0.80	090
53447		A	Remove/replace ur sphincter	14.15	NA	6.76	1.04	090
53448		A	Remov/reple ur sphincter comp	23.26	NA	9.95	1.69	090
53449		A	Repair uro sphincter	10.43	NA	5.30	0.77	090
53450		A	Revision of urethra	6.67	NA	3.79	0.49	090
53460		A	Revision of urethra	7.65	NA	4.09	0.55	090
53500		A	Urethrlys, transvag w/ scope	12.87	NA	6.41	1.09	090
53502		A	Repair of urethra injury	8.16	NA	4.33	0.59	090
53505		A	Repair of urethra injury	8.16	NA	4.32	0.59	090
53510		A	Repair of urethra injury	10.83	NA	5.40	0.78	090
53515		A	Repair of urethra injury	14.09	NA	6.47	1.02	090
53520		A	Repair of urethra defect	9.35	NA	4.92	0.68	090
53600		A	Dilate urethra stricture	1.21	0.92	0.47	0.09	000
53601		A	Dilate urethra stricture	0.98	1.06	0.42	0.07	000
53605		A	Dilate urethra stricture	1.28	NA	0.42	0.10	000
53620		A	Dilate urethra stricture	1.62	1.33	0.67	0.12	000
53621		A	Dilate urethra stricture	1.35	1.41	0.54	0.10	000
53660		A	Dilation of urethra	0.71	1.05	0.37	0.05	000
53661		A	Dilation of urethra	0.72	1.01	0.34	0.05	000
53665		A	Dilation of urethra	0.76	NA	0.26	0.06	000
53850		A	Prostatic microwave thermotx	9.98	37.54	4.69	0.73	090
53852		A	Prostatic rf thermotx	10.68	35.36	5.31	0.78	090
53899		C	Urology surgery procedure	0.00	0.00	0.00	0.00	YYY
54000		A	Slitting of prepuce	1.56	2.09	1.17	0.11	010
54001		A	Slitting of prepuce	2.21	2.40	1.33	0.17	010
54015		A	Drain penis lesion	5.33	NA	2.69	0.41	010
54050		A	Destruction, penis lesion(s)	1.26	2.02	1.39	0.08	010
54055		A	Destruction, penis lesion(s)	1.23	1.72	1.12	0.09	010
54056		A	Cryosurgery, penis lesion(s)	1.26	2.27	1.54	0.07	010
54057		A	Laser surg, penis lesion(s)	1.26	2.13	1.13	0.10	010
54060		A	Excision of penis lesion(s)	1.95	2.52	1.37	0.15	010
54065		A	Destruction, penis lesion(s)	2.44	3.08	1.98	0.16	010
54100		A	Biopsy of penis	1.90	3.03	1.38	0.12	000
54105		A	Biopsy of penis	3.51	3.15	1.97	0.26	010
54110		A	Treatment of penis lesion	10.79	NA	5.27	0.78	090
54111		A	Treat penis lesion, graft	14.29	NA	6.42	1.04	090
54112		A	Treat penis lesion, graft	16.83	NA	7.44	1.22	090
54115		A	Treatment of penis lesion	6.82	4.60	3.98	0.49	090
54120		A	Partial removal of penis	10.88	NA	5.39	0.80	090
54125		A	Removal of penis	14.43	NA	6.61	1.09	090
54130		A	Remove penis & nodes	21.66	NA	9.27	1.57	090

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CPT[1,2]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
54135		A	Remove penis & nodes	27.99	NA	11.34	2.03	090
54150		A	Circumcision w/regional block	1.90	2.04	0.68	0.16	000
54160		A	Circumcision, neonate	2.50	2.98	1.21	0.18	010
54161		A	Circum 28 days or older	3.29	NA	1.77	0.25	010
54162		A	Lysis penil circumic lesion	3.27	3.17	1.83	0.24	010
54163		A	Repair of circumcision	3.27	NA	2.28	0.24	010
54164		A	Frenulotomy of penis	2.77	NA	2.12	0.20	010
54200		A	Treatment of penis lesion	1.08	1.57	1.03	0.08	010
54205		A	Treatment of penis lesion	8.84	NA	4.79	0.64	090
54220		A	Treatment of penis lesion	2.42	2.63	1.10	0.18	000
54230		A	Prepare penis study	1.34	1.12	0.73	0.10	000
54231		A	Dynamic cavernosometry	2.04	1.54	0.99	0.15	000
54235		A	Penile injection	1.19	1.11	0.73	0.09	000
54240		A	Penis study	1.31	1.23	1.23	0.10	000
54240	TC	A	Penis study	0.00	0.80	0.00	0.00	000
54240	26	A	Penis study	1.31	0.43	0.43	0.09	000
54250		A	Penis study	2.22	1.02	1.02	0.16	000
54250	TC	A	Penis study	0.00	0.28	0.28	0.01	000
54250	26	A	Penis study	2.22	0.74	0.74	0.15	000
54300		A	Revision of penis	11.07	NA	5.47	0.80	090
54304		A	Revision of penis	13.15	NA	6.21	0.95	090
54308		A	Reconstruction of urethra	12.49	NA	5.96	0.90	090
54312		A	Reconstruction of urethra	14.36	NA	6.76	1.04	090
54316		A	Reconstruction of urethra	17.90	NA	7.95	1.30	090
54318		A	Reconstruction of urethra	12.28	NA	6.65	0.66	090
54322		A	Reconstruction of urethra	13.85	NA	6.34	1.00	090
54324		A	Reconstruction of urethra	17.40	NA	7.69	1.26	090
54326		A	Reconstruction of urethra	16.87	NA	7.61	1.22	090
54328		A	Revise penis/urethra	16.74	NA	7.57	1.21	090
54332		A	Revise penis/urethra	18.22	NA	8.05	1.32	090
54336		A	Revise penis/urethra	21.44	NA	9.38	1.55	090
54340		A	Secondary urethral surgery	9.58	NA	5.04	0.69	090
54344		A	Secondary urethral surgery	16.91	NA	7.62	1.23	090
54348		A	Secondary urethral surgery	18.17	NA	8.96	0.97	090
54352		A	Reconstruct urethra/penis	25.95	NA	10.86	1.88	090
54360		A	Penis plastic surgery	12.65	NA	5.97	0.92	090
54380		A	Repair penis	14.03	NA	6.59	1.02	090
54385		A	Repair penis	16.38	NA	10.10	1.83	090
54390		A	Repair penis and bladder	22.59	NA	9.60	1.64	090
54400		A	Insert semi-rigid prosthesis	9.09	NA	4.58	0.66	090
54401		A	Insert self-contd prosthesis	10.26	NA	6.41	0.75	090
54405		A	Insert multi-comp penis pros	14.39	NA	6.55	1.05	090
54406		A	Remove multi-comp penis pros	12.76	NA	6.09	0.93	090
54408		A	Repair multi-comp penis pros	13.73	NA	6.63	1.02	090
54410		A	Remove/replace penis prosth	16.01	NA	7.50	1.09	090
54411		A	Remov/replc penis pros, comp	18.14	NA	8.40	1.31	090
54415		A	Remove self-contd penis pros	8.75	NA	4.78	0.64	090
54416		A	Remv/repl penis contain pros	11.87	NA	6.29	0.86	090
54417		A	Remv/replc penis pros, compl	15.94	NA	7.28	1.15	090
54420		A	Revision of penis	12.26	NA	5.91	0.89	090
54430		A	Revision of penis	10.93	NA	5.53	0.79	090
54435		A	Revision of penis	6.71	NA	3.93	0.49	090
54440		C	Repair of penis	0.00	NA	0.00	0.00	090
54450		A	Preputial stretching	1.12	0.68	0.40	0.08	000
54500		A	Biopsy of testis	1.31	NA	0.63	0.09	000
54505		A	Biopsy of testis	3.47	NA	1.93	0.25	010
54512		A	Excise lesion testis	9.23	NA	4.63	0.69	090
54520		A	Removal of testis	5.25	NA	3.10	0.45	090
54522		A	Orchiectomy, partial	10.15	NA	5.06	0.74	090
54530		A	Removal of testis	8.65	NA	4.71	0.65	090
54535		A	Extensive testis surgery	13.06	NA	6.15	0.95	090
54550		A	Exploration for testis	8.31	NA	4.33	0.60	090
54560		A	Exploration for testis	11.97	NA	5.73	0.87	090
54600		A	Reduce testis torsion	7.54	NA	4.08	0.55	090
54620		A	Suspension of testis	5.16	NA	2.57	0.37	010
54640		A	Suspension of testis	7.57	NA	4.54	0.65	090
54650		A	Orchiopexy (Fowler-Stephens)	12.24	NA	6.07	0.89	090
54660		A	Revision of testis	5.64	NA	3.45	0.41	090
54670		A	Repair testis injury	6.57	NA	3.81	0.48	090
54680		A	Relocation of testis(es)	13.91	NA	6.43	1.01	090
54690		A	Laparoscopy, orchiectomy	11.60	NA	6.66	1.88	090
54692		A	Laparoscopy, orchiopexy	13.64	NA	6.04	2.21	090
54699		C	Laparoscope proc, testis	0.00	0.00	0.00	0.00	YYY
54700		A	Drainage of scrotum	3.44	NA	2.05	0.29	010
54800		A	Biopsy of epididymis	2.33	NA	1.68	0.17	000
54830		A	Remove epididymis lesion	5.91	NA	3.61	0.46	090
54840		A	Remove epididymis lesion	5.22	NA	3.02	0.39	090
54860		A	Removal of epididymis	6.85	NA	3.86	0.50	090
54861		A	Removal of epididymis	9.57	NA	4.95	0.69	090
54865		A	Explore epididymis	5.67	NA	3.46	0.41	090
54900		A	Fusion of spermatic ducts	14.05	NA	7.29	0.75	090
54901		A	Fusion of spermatic ducts	18.92	NA	9.30	1.01	090
55000		A	Drainage of hydrocele	1.43	1.54	0.78	0.11	000
55040		A	Removal of hydrocele	5.39	NA	3.26	0.45	090

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
55041		A	Removal of hydroceles	8.41	NA	4.63	0.67	090
55060		A	Repair of hydrocele	6.05	NA	3.66	0.50	090
55100		A	Drainage of scrotum abscess	2.40	2.94	1.80	0.21	010
55110		A	Explore scrotum	6.23	NA	3.65	0.50	090
55120		A	Removal of scrotum lesion	5.62	NA	3.48	0.45	090
55150		A	Removal of scrotum	8.01	NA	4.52	0.63	090
55175		A	Revision of scrotum	5.77	NA	3.48	0.44	090
55180		A	Revision of scrotum	11.63	NA	6.02	0.94	090
55200		A	Incision of sperm duct	4.50	6.29	2.63	0.33	090
55250		A	Removal of sperm duct(s)	3.32	6.09	2.44	0.24	090
55300		A	Prepare, sperm duct x-ray	3.50	NA	1.41	0.25	000
55400		A	Repair of sperm duct	8.53	NA	4.32	0.62	090
55450		A	Ligation of sperm duct	4.38	4.59	2.24	0.32	010
55500		A	Removal of hydrocele	6.12	NA	3.88	0.66	090
55520		A	Removal of sperm cord lesion	6.56	NA	4.63	1.01	090
55530		A	Revise spermatic cord veins	5.69	NA	3.35	0.46	090
55535		A	Revise spermatic cord veins	7.09	NA	3.93	0.51	090
55540		A	Revise hernia & sperm veins	8.20	NA	5.15	1.23	090
55550		A	Laparo ligate spermatic vein	7.10	NA	3.87	0.51	090
55559		C	Laparo proc, spermatic cord	0.00	0.00	0.00	0.00	YYY
55600		A	Incise sperm duct pouch	6.91	NA	3.87	0.50	090
55605		A	Incise sperm duct pouch	8.63	NA	4.71	0.63	090
55650		A	Remove sperm duct pouch	12.52	NA	6.04	0.91	090
55680		A	Remove sperm pouch lesion	5.59	NA	3.26	0.40	090
55700		A	Biopsy of prostate	2.58	2.89	1.07	0.19	000
55705		A	Biopsy of prostate	4.58	NA	2.30	0.34	010
55706		A	Prostate saturation sampling	6.15	NA	3.40	0.33	010
55720		A	Drainage of prostate abscess	7.67	NA	3.99	0.56	090
55725		A	Drainage of prostate abscess	9.90	NA	5.29	0.72	090
55801		A	Removal of prostate	19.62	NA	8.68	1.42	090
55810		A	Extensive prostate surgery	24.14	NA	10.13	1.86	090
55812		A	Extensive prostate surgery	29.69	NA	12.15	2.15	090
55815		A	Extensive prostate surgery	32.75	NA	13.16	2.37	090
55821		A	Removal of prostate	15.63	NA	7.02	1.14	090
55831		A	Removal of prostate	17.06	NA	7.50	1.24	090
55840		A	Extensive prostate surgery	24.45	NA	10.32	1.79	090
55842		A	Extensive prostate surgery	26.31	NA	10.92	1.92	090
55845		A	Extensive prostate surgery	30.52	NA	12.17	2.25	090
55860		A	Surgical exposure, prostate	15.71	NA	6.93	1.13	090
55862		A	Extensive prostate surgery	19.89	NA	10.36	1.44	090
55865		A	Extensive prostate surgery	24.39	NA	10.26	1.77	090
55866		A	Laparo radical prostatectomy	32.25	NA	13.11	2.36	090

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55870		A	Electroejaculation	2.58	1.90	1.14	0.19	000
55873		A	Cryoablate prostate	20.25	NA	9.06	1.50	090
55875		A	Transperi needle place, pros	13.31	NA	6.37	0.96	090
55876		A	Place rt device/marker, pros	1.73	1.70	0.89	0.12	000
55899		C	Genital surgery procedure	0.00	0.00	0.00	0.00	YYY
55920		A	Place needles pelvic for rt	8.31	NA	3.43	0.53	000
56405		A	I & D of vulva/perineum	1.46	1.27	1.25	0.11	010
56420		A	Drainage of gland abscess	1.41	1.61	0.90	0.11	010
56440		A	Surgery for vulva lesion	2.86	NA	1.78	0.20	010
56441		A	Lysis of labial lesion(s)	1.99	1.61	1.49	0.13	010
56442		A	Hymenotomy	0.68	NA	0.54	0.04	000
56501		A	Destroy, vulva lesions, sim	1.55	1.68	1.31	0.10	010
56515		A	Destroy vulva lesion/s compl	3.03	2.56	1.99	0.20	010
56605		A	Biopsy of vulva/perineum	1.10	0.97	0.46	0.07	000
56606		A	Biopsy of vulva/perineum	0.55	0.40	0.21	0.04	ZZZ
56620		A	Partial removal of vulva	7.35	NA	5.22	0.69	090
56625		A	Complete removal of vulva	9.55	NA	5.73	0.80	090
56630		A	Extensive vulva surgery	14.67	NA	7.87	1.18	090
56631		A	Extensive vulva surgery	18.81	NA	9.89	1.42	090
56632		A	Extensive vulva surgery	21.61	NA	11.71	1.68	090
56633		A	Extensive vulva surgery	19.47	NA	10.02	1.62	090
56634		A	Extensive vulva surgery	20.48	NA	10.69	0.99	090
56637		A	Extensive vulva surgery	24.57	NA	11.94	1.93	090
56640		A	Extensive vulva surgery	24.65	NA	11.97	1.20	090
56700		A	Partial removal of hymen	2.79	NA	1.91	0.18	010
56740		A	Remove vagina gland lesion	4.83	NA	2.73	0.39	010
56800		A	Repair of vagina	3.90	NA	2.22	0.27	010
56805		A	Repair clitoris	19.75	NA	9.52	2.53	090
56810		A	Repair of perineum	4.26	NA	2.36	0.30	010
56820		A	Exam of vulva w/scope	1.50	1.28	0.69	0.09	000
56821		A	Exam/biopsy of vulva w/scope	2.05	1.65	0.90	0.13	000
57000		A	Exploration of vagina	2.99	NA	1.80	0.20	010
57010		A	Drainage of pelvic abscess	6.74	NA	4.21	0.86	090
57020		A	Drainage of pelvic fluid	1.50	0.88	0.60	0.10	000
57022		A	I & d vaginal hematoma, pp	2.70	NA	1.56	0.18	010
57023		A	I & d vag hematoma, non-ob	5.13	NA	2.77	0.34	010
57061		A	Destroy vag lesions, simple	1.27	1.53	1.17	0.08	010
57065		A	Destroy vag lesions, complex	2.63	2.17	1.70	0.17	010
57100		A	Biopsy of vagina	1.20	1.02	0.50	0.08	000
57105		A	Biopsy of vagina	1.71	1.63	1.40	0.11	010
57106		A	Remove vagina wall, partial	7.35	NA	4.80	0.77	090
57107		A	Remove vagina tissue, part	24.43	NA	11.57	2.20	090

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
57109		A	Vaginectomy partial w/nodes	28.25	NA	13.64	1.37	090
57110		A	Remove vagina wall, complete	15.38	NA	7.53	1.90	090
57111		A	Remove vagina tissue, compl	28.25	NA	13.64	3.61	090
57112		A	Vaginectomy w/nodes, compl	30.37	NA	14.50	1.47	090
57120		A	Closure of vagina	8.18	NA	4.75	1.01	090
57130		A	Remove vagina lesion	2.44	2.01	1.59	0.16	010
57135		A	Remove vagina lesion	2.68	2.13	1.69	0.18	010
57150		A	Treat vagina infection	0.55	0.59	0.21	0.04	000
57155		A	Insert uteri tandems/ovoids	6.79	NA	3.76	0.44	090
57160		A	Insert pessary/other device	0.89	1.03	0.34	0.06	000
57170		A	Fitting of diaphragm/cap	0.91	0.63	0.35	0.06	000
57180		A	Treat vaginal bleeding	1.60	1.88	1.05	0.11	010
57200		A	Repair of vagina	4.34	NA	3.14	0.51	090
57210		A	Repair vagina/perineum	5.63	NA	3.60	0.68	090
57220		A	Revision of urethra	4.77	NA	3.27	0.60	090
57230		A	Repair of urethral lesion	6.22	NA	3.77	0.80	090
57240		A	Repair bladder & vagina	11.42	NA	5.75	1.23	090
57250		A	Repair rectum & vagina	11.42	NA	5.88	1.39	090
57260		A	Repair of vagina	14.36	NA	7.00	1.75	090
57265		A	Extensive repair of vagina	15.86	NA	7.54	1.91	090
57267		A	Insert mesh/pelvic flr addon	4.88	NA	1.80	0.33	ZZZ
57268		A	Repair of bowel bulge	7.47	NA	4.72	0.89	090
57270		A	Repair of bowel pouch	13.57	NA	6.86	1.62	090
57280		A	Suspension of vagina	16.62	NA	7.84	1.89	090
57282		A	Colpopexy, extraperitoneal	7.84	NA	4.83	0.91	090
57283		A	Extensive repair of vagina	11.58	NA	6.04	1.43	090
57284		A	Repair paravag defect, open	14.25	NA	6.69	1.61	090
57285		A	Repair paravag defect, vag	11.52	NA	5.73	1.33	090
57287		A	Revise/remove sling repair	10.36	NA	6.07	1.07	090
57288		A	Repair bladder defect	12.00	NA	5.97	1.19	090
57289		A	Repair bladder & vagina	12.69	NA	6.13	0.92	090
57291		A	Construction of vagina	8.54	NA	4.89	1.09	090
57292		A	Construct vagina with graft	13.91	NA	7.34	0.67	090
57295		A	Revise vag graft via vagina	7.74	NA	4.44	0.88	090
57296		A	Revise vag graft, open abd	16.46	NA	7.87	2.10	090
57300		A	Repair rectum-vagina fistula	8.58	NA	5.51	1.10	090
57305		A	Repair rectum-vagina fistula	15.24	NA	8.19	2.17	090
57307		A	Fistula repair & colostomy	17.02	NA	9.44	2.76	090
57308		A	Fistula repair, transperine	10.48	NA	5.76	1.34	090
57310		A	Repair urethrovaginal lesion	7.55	NA	4.24	0.55	090
57311		A	Repair urethrovaginal lesion	8.81	NA	5.04	0.64	090
57320		A	Repair bladder-vagina lesion	8.78	NA	4.81	0.75	090
57330		A	Repair bladder-vagina lesion	13.11	NA	6.02	0.95	090
57335		A	Repair vagina	19.87	NA	9.66	2.54	090
57400		A	Dilation of vagina	2.27	NA	1.14	0.15	000
57410		A	Pelvic examination	1.75	NA	0.99	0.12	000
57415		A	Remove vaginal foreign body	2.44	NA	1.58	0.17	010
57420		A	Exam of vagina w/scope	1.60	1.33	0.73	0.10	000
57421		A	Exam/biopsy of vag w/scope	2.20	1.73	0.96	0.14	000
57423		A	Repair paravag defect, lap	16.00	NA	7.45	2.05	090
57425		A	Laparoscopy, surg, colpopexy	16.93	NA	8.02	1.95	090
57452		A	Exam of cervix w/scope	1.50	1.24	0.85	0.10	000
57454		A	Bx/curett of cervix w/scope	2.33	1.57	1.17	0.15	000
57455		A	Biopsy of cervix w/scope	1.99	1.61	0.87	0.13	000
57456		A	Endocerv curettage w/scope	1.85	1.55	0.81	0.12	000
57460		A	Bx of cervix w/scope, leep	2.83	4.19	1.36	0.18	000
57461		A	Conz of cervix w/scope, leep	3.43	4.52	1.42	0.22	000
57500		A	Biopsy of cervix	1.20	1.96	0.74	0.08	000
57505		A	Endocervical curettage	1.16	1.34	1.11	0.08	010
57510		A	Cauterization of cervix	1.90	1.42	1.06	0.13	010
57511		A	Cryocautery of cervix	1.92	1.70	1.40	0.13	010
57513		A	Laser surgery of cervix	1.92	1.66	1.40	0.13	010
57520		A	Conization of cervix	4.06	3.56	2.80	0.47	090
57522		A	Conization of cervix	3.62	2.94	2.49	0.45	090
57530		A	Removal of cervix	5.19	NA	3.47	0.59	090
57531		A	Removal of cervix, radical	29.77	NA	14.43	3.81	090
57540		A	Removal of residual cervix	13.19	NA	6.68	1.69	090
57545		A	Remove cervix/repair pelvis	14.00	NA	6.99	1.79	090
57550		A	Removal of residual cervix	6.24	NA	4.02	0.80	090
57555		A	Remove cervix/repair vagina	9.84	NA	5.42	1.26	090
57556		A	Remove cervix, repair bowel	9.26	NA	5.16	1.05	090
57558		A	D&c of cervical stump	1.69	1.42	1.16	0.11	010
57700		A	Revision of cervix	4.22	NA	3.48	0.54	090
57720		A	Revision of cervix	4.53	NA	3.19	0.58	090
57800		A	Dilation of cervical canal	0.77	0.74	0.47	0.05	000
58100		A	Biopsy of uterus lining	1.53	1.23	0.73	0.10	000
58110		A	Bx done w/colposcopy add-on	0.77	0.46	0.30	0.05	ZZZ
58120		A	Dilation and curettage	3.54	2.89	1.96	0.24	010
58140		A	Myomectomy abdom method	15.69	NA	7.71	2.09	090
58145		A	Myomectomy vag method	8.81	NA	4.97	1.09	090
58146		A	Myomectomy abdom complex	20.24	NA	9.31	2.59	090
58150		A	Total hysterectomy	17.21	NA	8.27	1.97	090
58152		A	Total hysterectomy	21.73	NA	10.14	2.66	090
58180		A	Partial hysterectomy	16.50	NA	7.97	1.95	090

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58200		A	Extensive hysterectomy	23.00	NA	10.73	2.05	090
58210		A	Extensive hysterectomy	30.76	NA	14.36	2.36	090
58240		A	Removal of pelvis contents	49.02	NA	22.40	4.02	090
58260		A	Vaginal hysterectomy	14.02	NA	7.04	1.76	090
58262		A	Vag hyst including t/o	15.81	NA	7.71	1.98	090
58263		A	Vag hyst w/t/o & vag repair	17.10	NA	8.24	2.12	090
58267		A	Vag hyst w/urinary repair	18.23	NA	8.74	2.26	090
58270		A	Vag hyst w/enterocele repair	15.20	NA	7.32	1.90	090
58275		A	Hysterectomy/revise vagina	16.90	NA	8.22	2.08	090
58280		A	Hysterectomy/revise vagina	18.20	NA	8.75	2.20	090
58285		A	Extensive hysterectomy	23.30	NA	10.36	1.13	090
58290		A	Vag hyst complex	20.17	NA	9.30	2.53	090
58291		A	Vag hyst incl t/o, complex	21.96	NA	9.97	2.81	090
58292		A	Vag hyst t/o & repair, compl	23.25	NA	10.46	2.97	090
58293		A	Vag hyst w/uro repair, compl	24.23	NA	10.84	3.10	090
58294		A	Vag hyst w/enterocele, compl	21.45	NA	9.77	2.74	090
58300		N	Insert intrauterine device	1.01	0.80	0.37	0.05	XXX
58301		A	Remove intrauterine device	1.27	1.13	0.48	0.08	000
58321		A	Artificial insemination	0.92	1.07	0.34	0.05	000
58322		A	Artificial insemination	1.10	1.06	0.42	0.07	000
58323		A	Sperm washing	0.23	0.16	0.09	0.02	000
58340		A	Catheter for hysterography	0.88	2.00	0.60	0.06	000
58345		A	Reopen fallopian tube	4.67	NA	2.45	0.31	010
58346		A	Insert heyman uteri capsule	7.48	NA	4.06	0.47	090
58350		A	Reopen fallopian tube	1.03	1.33	0.92	0.07	010
58353		A	Endometr ablate, thermal	3.57	20.53	2.00	0.24	010
58356		A	Endometrial cryoablation	6.36	38.91	2.52	0.42	010
58400		A	Suspension of uterus	7.06	NA	4.14	0.80	090
58410		A	Suspension of uterus	13.70	NA	6.82	1.75	090
58520		A	Repair of ruptured uterus	13.38	NA	7.42	2.17	090
58540		A	Revision of uterus	15.61	NA	7.61	2.00	090
58541		A	Lsh, uterus 250 g or less	14.57	NA	7.44	1.84	090
58542		A	Lsh w/t/o ut 250 g or less	16.43	NA	8.17	2.06	090
58543		A	Lsh uterus above 250 g	16.74	NA	8.33	2.14	090
58544		A	Lsh w/t/o uterus above 250 g	18.24	NA	8.87	2.33	090
58545		A	Laparoscopic myomectomy	15.45	NA	7.40	1.81	090
58546		A	Laparo-myomectomy, complex	19.84	NA	9.00	2.54	090
58548		A	Lap radical hyst	31.45	NA	14.92	2.20	090
58550		A	Laparo-asst vag hysterectomy	14.97	NA	7.50	1.88	090
58552		A	Laparo-vag hyst incl t/o	16.78	NA	8.22	1.91	090
58553		A	Laparo-vag hyst, complex	19.96	NA	9.08	2.55	090
58554		A	Laparo-vag hyst w/t/o, compl	22.98	NA	10.63	2.54	090
58555		A	Hysteroscopy, dx, sep proc	3.33	NA	1.55	0.22	000
58558		A	Hysteroscopy, biopsy	4.74	3.85	2.12	0.31	000
58559		A	Hysteroscopy, lysis	6.16	NA	2.66	0.41	000
58560		A	Hysteroscopy, resect septum	6.99	NA	2.98	0.46	000
58561		A	Hysteroscopy, remove myoma	9.99	NA	4.13	0.65	000
58562		A	Hysteroscopy, remove fb	5.20	3.81	2.27	0.34	000
58563		A	Hysteroscopy, ablation	6.16	33.55	2.66	0.40	000
58565		A	Hysteroscopy, sterilization	7.06	37.75	3.95	0.90	090
58570		A	Tlh, uterus 250 g or less	15.75	NA	7.96	1.81	090
58571		A	Tlh w/t/o 250 g or less	17.56	NA	8.85	1.56	090
58572		A	Tlh, uterus over 250 g	19.96	NA	9.49	2.55	090
58573		A	Tlh w/t/o uterus over 250 g	22.98	NA	10.98	2.09	090
58578		C	Laparo proc, uterus	0.00	0.00	0.00	0.00	YYY
58579		C	Hysteroscope procedure	0.00	0.00	0.00	0.00	YYY
58600		A	Division of fallopian tube	5.86	NA	3.39	0.75	090
58605		A	Division of fallopian tube	5.25	NA	3.13	0.67	090
58611		A	Ligate oviduct(s) add-on	1.45	NA	0.55	0.09	ZZZ
58615		A	Occlude fallopian tube(s)	3.91	NA	2.28	0.26	010
58660		A	Laparoscopy, lysis	11.54	NA	5.62	1.52	090
58661		A	Laparoscopy, remove adnexa	11.30	NA	5.16	0.77	010
58662		A	Laparoscopy, excise lesions	12.08	NA	5.91	1.50	090
58670		A	Laparoscopy, tubal cautery	5.86	NA	3.43	0.75	090
58671		A	Laparoscopy, tubal block	5.86	NA	3.41	0.76	090
58672		A	Laparoscopy, fimbrioplasty	12.88	NA	6.20	1.65	090
58673		A	Laparoscopy, salpingostomy	13.99	NA	6.51	1.79	090
58679		C	Laparo proc, oviduct-ovary	0.00	0.00	0.00	0.00	YYY
58700		A	Removal of fallopian tube	12.84	NA	6.83	1.80	090
58720		A	Removal of ovary/tube(s)	12.08	NA	6.29	1.44	090
58740		A	Adhesiolysis tube, ovary	14.79	NA	7.49	1.89	090
58750		A	Repair oviduct	15.56	NA	7.50	1.99	090
58752		A	Revise ovarian tube(s)	15.56	NA	7.39	0.83	090
58760		A	Fimbrioplasty	13.85	NA	6.84	1.77	090
58770		A	Create new tubal opening	14.69	NA	7.11	1.88	090
58800		A	Drainage of ovarian cyst(s)	4.54	3.41	2.96	0.58	090
58805		A	Drainage of ovarian cyst(s)	6.34	NA	4.62	1.03	090
58820		A	Drain ovary abscess, open	4.62	NA	3.22	0.59	090
58822		A	Drain ovary abscess, percut	11.71	NA	6.89	1.90	090
58823		A	Drain pelvic abscess, percut	3.37	14.89	1.05	0.28	000
58825		A	Transposition, ovary(s)	11.70	NA	6.02	1.50	090
58900		A	Biopsy of ovary(s)	6.51	NA	4.68	1.05	090
58920		A	Partial removal of ovary(s)	11.87	NA	6.00	1.52	090
58925		A	Removal of ovarian cyst(s)	12.33	NA	6.47	1.65	090

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58940		A	Removal of ovary(s)	8.12	NA	4.86	1.10	090
58943		A	Removal of ovary(s)	19.42	NA	9.37	1.84	090
58950		A	Resect ovarian malignancy	18.24	NA	9.27	1.60	090
58951		A	Resect ovarian malignancy	24.15	NA	11.37	2.00	090
58952		A	Resect ovarian malignancy	27.15	NA	12.94	2.21	090
58953		A	Tah, rad dissect for debulk	33.97	NA	15.74	2.61	090
58954		A	Tah rad debulk/lymph remove	36.97	NA	16.93	2.93	090
58956		A	Bso, omentectomy w/tah	22.65	NA	11.12	2.08	090
58957		A	Resect recurrent gyn mal	26.06	NA	12.58	2.21	090
58958		A	Resect recur gyn mal w/lym	29.06	NA	13.86	2.35	090
58960		A	Exploration of abdomen	15.68	NA	7.98	1.49	090
58970		A	Retrieval of oocyte	3.52	2.21	1.63	0.19	000
58974		C	Transfer of embryo	0.00	0.00	0.00	0.00	000
58976		A	Transfer of embryo	3.82	2.54	1.74	0.20	000
58999		C	Genital surgery procedure	0.00	0.00	0.00	0.00	YYY
59000		A	Amniocentesis, diagnostic	1.30	1.72	0.66	0.28	000
59001		A	Amniocentesis, therapeutic	3.00	NA	1.36	0.65	000
59012		A	Fetal cord puncture,prenatal	3.44	NA	1.48	0.75	000
59015		A	Chorion biopsy	2.20	1.56	1.01	0.48	000
59020		A	Fetal contract stress test	0.66	1.04	1.04	0.14	000
59020	TC	A	Fetal contract stress test	0.00	0.79	0.00	0.00	000
59020	26	A	Fetal contract stress test	0.66	0.25	0.25	0.14	000
59025		A	Fetal non-stress test	0.53	0.63	0.63	0.11	000
59025	TC	A	Fetal non-stress test	0.00	0.43	0.00	0.00	000
59025	26	A	Fetal non-stress test	0.53	0.20	0.20	0.11	000
59030		A	Fetal scalp blood sample	1.99	NA	0.73	0.11	000
59050		A	Fetal monitor w/report	0.89	NA	0.34	0.09	XXX
59051		A	Fetal monitor/interpret only	0.74	NA	0.28	0.16	XXX
59070		A	Transabdom amnioinfus w/us	5.24	4.68	2.29	1.14	000
59072		A	Umbilical cord occlud w/us	8.99	NA	3.63	0.48	000
59074		A	Fetal fluid drainage w/us	5.24	4.95	2.46	1.14	000
59076		A	Fetal shunt placement, w/us	8.99	NA	3.75	1.96	000
59100		A	Remove uterus lesion	13.26	NA	6.78	2.89	090
59120		A	Treat ectopic pregnancy	12.56	NA	6.52	2.74	090
59121		A	Treat ectopic pregnancy	12.64	NA	6.47	2.76	090
59130		A	Treat ectopic pregnancy	14.98	NA	7.34	0.80	090
59135		A	Treat ectopic pregnancy	14.82	NA	7.22	0.79	090
59136		A	Treat ectopic pregnancy	14.15	NA	6.99	3.09	090
59140		A	Treat ectopic pregnancy	5.86	NA	3.83	0.31	090
59150		A	Treat ectopic pregnancy	12.19	NA	6.30	2.66	090
59151		A	Treat ectopic pregnancy	12.01	NA	5.97	2.62	090
59160		A	D & c after delivery	2.73	2.14	1.42	0.60	010
59200		A	Insert cervical dilator	0.79	0.94	0.30	0.17	000
59300		A	Episiotomy or vaginal repair	2.41	2.24	1.20	0.53	000
59320		A	Revision of cervix	2.48	NA	1.22	0.53	000
59325		A	Revision of cervix	4.06	NA	1.80	0.22	000
59350		A	Repair of uterus	4.94	NA	1.87	1.08	000
59400		A	Obstetrical care	26.80	NA	16.34	5.59	MMM
59409		A	Obstetrical care	13.48	NA	5.19	2.78	MMM
59410		A	Obstetrical care	15.29	NA	6.52	3.19	MMM
59412		A	Antepartum manipulation	1.71	NA	0.80	0.37	MMM
59414		A	Deliver placenta	1.61	NA	0.62	0.35	MMM
59425		A	Antepartum care only	6.22	4.70	2.37	1.27	MMM
59426		A	Antepartum care only	11.04	8.61	4.21	2.20	MMM
59430		A	Care after delivery	2.13	1.27	0.93	0.44	MMM
59510		A	Cesarean delivery	30.34	NA	18.33	6.54	MMM
59514		A	Cesarean delivery only	15.95	NA	6.17	3.43	MMM
59515		A	Cesarean delivery	18.26	NA	7.99	3.90	MMM
59525		A	Remove uterus after cesarean	8.53	NA	3.27	1.86	ZZZ
59610		A	Vbac delivery	28.21	NA	17.12	6.16	MMM
59612		A	Vbac delivery only	15.04	NA	5.81	3.28	MMM
59614		A	Vbac care after delivery	16.59	NA	6.82	3.62	MMM
59618		A	Attempted vbac delivery	31.78	NA	18.97	6.94	MMM
59620		A	Attempted vbac delivery only	17.50	NA	6.76	3.82	MMM
59622		A	Attempted vbac after care	19.70	NA	8.69	4.30	MMM
59812		A	Treatment of miscarriage	4.39	3.34	2.69	0.95	090
59820		A	Care of miscarriage	4.68	4.23	3.70	1.02	090
59821		A	Treatment of miscarriage	4.97	4.07	3.49	1.08	090
59830		A	Treat uterus infection	6.51	NA	3.93	1.42	090
59840		R	Abortion	3.01	2.25	2.04	0.60	010
59841		R	Abortion	5.57	3.55	3.05	1.22	010
59850		R	Abortion	5.90	NA	3.34	0.32	090
59851		R	Abortion	5.92	NA	3.71	1.29	090
59852		R	Abortion	8.23	NA	5.08	0.44	090
59855		R	Abortion	6.38	NA	3.59	1.39	090
59856		R	Abortion	7.74	NA	3.99	1.69	090
59857		R	Abortion	9.30	NA	4.48	0.50	090
59866		R	Abortion (mpr)	3.99	NA	1.80	0.21	000
59870		A	Evacuate mole of uterus	6.40	NA	4.76	1.40	090
59871		A	Remove cerclage suture	2.13	NA	1.12	0.46	000
59897		C	Fetal invas px w/us	0.00	0.00	0.00	0.00	YYY
59898		C	Laparo proc, ob care/deliver	0.00	0.00	0.00	0.00	YYY
59899		C	Maternity care procedure	0.00	0.00	0.00	0.00	YYY
60000		A	Drain thyroid/tongue cyst	1.78	2.39	1.98	0.12	010

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CPT[1]/HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
60100		A	Biopsy of thyroid	1.56	1.25	0.50	0.12	000
60200		A	Remove thyroid lesion	9.91	NA	6.84	1.29	090
60210		A	Partial thyroid excision	11.15	NA	6.77	1.55	090
60212		A	Partial thyroid excision	16.32	NA	9.29	2.30	090
60220		A	Partial removal of thyroid	12.29	NA	7.38	1.62	090
60225		A	Partial removal of thyroid	14.67	NA	8.93	1.99	090
60240		A	Removal of thyroid	16.18	NA	8.61	2.23	090
60252		A	Removal of thyroid	21.88	NA	11.80	2.94	090
60254		A	Extensive thyroid surgery	28.29	NA	14.99	3.41	090
60260		A	Repeat thyroid surgery	18.18	NA	9.89	2.36	090
60270		A	Removal of thyroid	23.07	NA	11.80	3.29	090
60271		A	Removal of thyroid	17.54	NA	9.57	2.27	090
60280		A	Remove thyroid duct lesion	6.05	NA	5.36	0.63	090
60281		A	Remove thyroid duct lesion	8.71	NA	6.65	0.85	090
60300		A	Aspir/inj thyroid cyst	0.97	1.84	0.31	0.08	000
60500		A	Explore parathyroid glands	16.69	NA	9.14	2.44	090
60502		A	Re-explore parathyroids	21.01	NA	11.31	3.14	090
60505		A	Explore parathyroid glands	22.91	NA	12.46	3.25	090
60512		A	Autotransplant parathyroid	4.44	NA	1.76	0.59	ZZZ
60520		A	Removal of thymus gland	17.07	NA	8.89	2.62	090
60521		A	Removal of thymus gland	19.11	NA	9.26	3.44	090
60522		A	Removal of thymus gland	23.37	NA	11.06	4.14	090
60540		A	Explore adrenal gland	17.91	NA	8.74	2.28	090
60545		A	Explore adrenal gland	20.82	NA	9.91	2.75	090
60600		A	Remove carotid body lesion	24.99	NA	10.79	3.99	090
60605		A	Remove carotid body lesion	31.86	NA	18.65	3.11	090
60650		A	Laparoscopy adrenalectomy	20.63	NA	9.52	2.80	090
60659		C	Laparo proc, endocrine	0.00	0.00	0.00	0.00	YYY
60699		C	Endocrine surgery procedure	0.00	0.00	0.00	0.00	YYY
61000		A	Remove cranial cavity fluid	1.58	NA	1.33	0.11	000
61001		A	Remove cranial cavity fluid	1.49	NA	2.02	0.41	000
61020		A	Remove brain cavity fluid	1.51	NA	1.71	0.30	000
61026		A	Injection into brain canal	1.69	NA	1.44	0.22	000
61050		A	Remove brain canal fluid	1.51	NA	1.18	0.13	000
61055		A	Injection into brain canal	2.10	NA	1.33	0.20	000
61070		A	Brain canal shunt procedure	0.89	NA	1.20	0.14	000
61105		A	Twist drill hole	5.40	NA	5.22	1.47	090
61107		A	Drill skull for implantation	4.99	NA	2.33	1.31	000
61108		A	Drill skull for drainage	11.51	NA	9.47	3.09	090
61120		A	Burr hole for puncture	9.52	NA	7.82	2.59	090
61140		A	Pierce skull for biopsy	17.10	NA	12.02	4.58	090
61150		A	Pierce skull for drainage	18.80	NA	12.59	5.11	090
61151		A	Pierce skull for drainage	13.41	NA	9.64	3.65	090
61154		A	Pierce skull & remove clot	16.92	NA	12.46	4.57	090
61156		A	Pierce skull for drainage	17.37	NA	11.40	4.72	090
61210		A	Pierce skull, implant device	5.83	NA	2.71	1.52	000
61215		A	Insert brain-fluid device	5.77	NA	5.96	1.55	090
61250		A	Pierce skull & explore	11.41	NA	8.70	3.10	090
61253		A	Pierce skull & explore	13.41	NA	8.18	1.31	090
61304		A	Open skull for exploration	23.31	NA	14.85	6.11	090
61305		A	Open skull for exploration	28.51	NA	18.03	7.75	090
61312		A	Open skull for drainage	30.07	NA	18.16	8.13	090
61313		A	Open skull for drainage	27.94	NA	18.00	7.56	090
61314		A	Open skull for drainage	25.77	NA	16.64	6.98	090
61315		A	Open skull for drainage	29.52	NA	18.41	8.03	090
61316		A	Implt cran bone flap to abdo	1.39	NA	0.65	0.37	ZZZ
61320		A	Open skull for drainage	27.32	NA	16.85	7.28	090
61321		A	Open skull for drainage	30.40	NA	18.92	8.27	090
61322		A	Decompressive craniotomy	34.08	NA	20.87	9.14	090
61323		A	Decompressive lobectomy	34.93	NA	20.24	9.24	090
61330		A	Decompress eye socket	25.17	NA	17.53	6.84	090
61332		A	Explore/biopsy eye socket	28.50	NA	17.48	7.75	090
61333		A	Explore orbit/remove lesion	29.17	NA	19.63	1.52	090
61334		A	Explore orbit/remove object	19.50	NA	13.26	5.30	090
61340		A	Subtemporal decompression	20.01	NA	13.50	5.44	090
61343		A	Incise skull (press relief)	31.73	NA	19.25	8.53	090
61345		A	Relieve cranial pressure	29.10	NA	18.13	7.91	090
61440		A	Incise skull for surgery	28.53	NA	17.86	7.76	090
61450		A	Incise skull for surgery	27.59	NA	16.95	7.50	090
61458		A	Incise skull for brain wound	28.71	NA	17.77	7.76	090
61460		A	Incise skull for surgery	30.11	NA	18.60	8.19	090
61470		A	Incise skull for surgery	27.52	NA	16.92	7.48	090
61480		A	Incise skull for surgery	27.95	NA	12.05	1.50	090
61490		A	Incise skull for surgery	27.12	NA	16.73	7.37	090
61500		A	Removal of skull lesion	19.05	NA	12.85	4.38	090
61501		A	Remove infected skull bone	16.22	NA	11.56	3.55	090
61510		A	Removal of brain lesion	30.63	NA	19.91	8.28	090
61512		A	Remove brain lining lesion	36.99	NA	22.10	10.01	090
61514		A	Removal of brain abscess	27.10	NA	17.05	7.31	090
61516		A	Removal of brain lesion	26.45	NA	16.40	7.19	090
61517		A	Implt brain chemotx add-on	1.38	NA	0.64	0.37	ZZZ
61518		A	Removal of brain lesion	39.69	NA	24.24	10.76	090
61519		A	Remove brain lining lesion	43.28	NA	24.97	11.69	090
61520		A	Removal of brain lesion	56.89	NA	31.53	13.77	090

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
61521		A	Removal of brain lesion	46.84	NA	26.86	12.73	090
61522		A	Removal of brain abscess	31.41	NA	19.21	8.54	090
61524		A	Removal of brain lesion	29.76	NA	18.44	8.09	090
61526		A	Removal of brain lesion	53.90	NA	28.27	14.65	090
61530		A	Removal of brain lesion	45.43	NA	25.80	12.35	090
61531		A	Implant brain electrodes	16.28	NA	12.02	4.43	090
61533		A	Implant brain electrodes	21.36	NA	13.89	5.79	090
61534		A	Removal of brain lesion	22.88	NA	15.21	6.22	090
61535		A	Remove brain electrodes	13.05	NA	10.12	3.55	090
61536		A	Removal of brain lesion	37.59	NA	22.11	10.22	090
61537		A	Removal of brain tissue	36.35	NA	20.58	9.82	090
61538		A	Removal of brain tissue	39.35	NA	22.47	10.70	090
61539		A	Removal of brain tissue	34.15	NA	20.50	9.28	090
61540		A	Removal of brain tissue	31.30	NA	19.24	8.51	090
61541		A	Incision of brain tissue	30.81	NA	18.93	8.38	090
61542		A	Removal of brain tissue	33.03	NA	19.84	8.98	090
61543		A	Removal of brain tissue	31.18	NA	19.10	8.48	090
61544		A	Remove & treat brain lesion	27.26	NA	16.80	1.46	090
61545		A	Excision of brain tumor	46.23	NA	27.44	12.57	090
61546		A	Removal of pituitary gland	33.31	NA	20.10	9.06	090
61548		A	Removal of pituitary gland	23.27	NA	14.12	5.04	090
61550		A	Release of skull seams	15.44	NA	11.98	0.83	090
61552		A	Release of skull seams	20.27	NA	9.53	1.09	090
61556		A	Incise skull/sutures	24.00	NA	15.49	6.53	090
61557		A	Incise skull/sutures	23.16	NA	15.74	6.30	090
61558		A	Excision of skull/sutures	26.35	NA	17.11	7.16	090
61559		A	Excision of skull/sutures	33.82	NA	15.02	1.81	090
61563		A	Excision of skull tumor	28.35	NA	17.53	7.71	090
61564		A	Excision of skull tumor	34.59	NA	21.11	9.40	090
61566		A	Removal of brain tissue	32.32	NA	19.72	8.79	090
61567		A	Incision of brain tissue	36.84	NA	22.48	10.02	090
61570		A	Remove foreign body, brain	26.38	NA	16.85	7.17	090
61571		A	Incise skull for brain wound	28.29	NA	17.75	7.69	090
61575		A	Skull base/brainstem surgery	36.43	NA	21.57	9.90	090
61576		A	Skull base/brainstem surgery	55.11	NA	35.28	5.37	090
61580		A	Craniofacial approach, skull	34.34	NA	27.53	4.27	090
61581		A	Craniofacial approach, skull	38.88	NA	31.38	3.79	090
61582		A	Craniofacial approach, skull	34.93	NA	36.42	9.50	090
61583		A	Craniofacial approach, skull	38.41	NA	29.45	9.90	090
61584		A	Orbitocranial approach/skull	37.61	NA	28.82	9.49	090
61585		A	Orbitocranial approach/skull	42.46	NA	33.03	11.54	090
61586		A	Resect nasopharynx, skull	27.28	NA	30.04	7.42	090

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61590		A	Infratemporal approach/skull	46.87	NA	31.01	6.31	090
61591		A	Infratemporal approach/skull	46.87	NA	31.12	6.99	090
61592		A	Orbitocranial approach/skull	42.98	NA	31.24	10.74	090
61595		A	Transtemporal approach/skull	33.57	NA	25.41	5.31	090
61596		A	Transcochlear approach/skull	39.31	NA	25.52	3.83	090
61597		A	Transcondylar approach/skull	40.73	NA	28.27	11.07	090
61598		A	Transpetrosal approach/skull	36.41	NA	29.66	9.90	090
61600		A	Resect/excise cranial lesion	29.84	NA	23.98	4.62	090
61601		A	Resect/excise cranial lesion	31.04	NA	25.15	7.67	090
61605		A	Resect/excise cranial lesion	32.40	NA	24.18	3.63	090
61606		A	Resect/excise cranial lesion	41.94	NA	28.99	10.40	090
61607		A	Resect/excise cranial lesion	40.82	NA	27.02	11.10	090
61608		A	Resect/excise cranial lesion	45.45	NA	30.32	11.57	090
61609		A	Transect artery, sinus	9.88	NA	4.64	0.64	ZZZ
61610		A	Transect artery, sinus	29.63	NA	13.91	1.59	ZZZ
61611		A	Transect artery, sinus	7.41	NA	2.70	0.40	ZZZ
61612		A	Transect artery, sinus	27.84	NA	.	1.49	ZZZ
61613		A	Remove aneurysm, sinus	44.94	NA	31.40	12.22	090
61615		A	Resect/excise lesion, skull	35.63	NA	23.92	3.47	090
61616		A	Resect/excise lesion, skull	46.60	NA	32.23	10.89	090
61618		A	Repair dura	18.58	NA	12.34	4.33	090
61619		A	Repair dura	22.01	NA	13.71	4.78	090
61623		A	Endovasc tempory vessel occl	9.95	NA	3.76	1.31	000
61624		A	Transcath occlusion, cns	20.12	NA	7.14	2.74	000
61626		A	Transcath occlusion, non-cns	16.60	NA	5.26	1.52	000
61630		R	Intracranial angioplasty	22.07	NA	9.12	2.67	XXX
61635		R	Intracran angioplsty w/stent	24.28	NA	9.87	2.92	XXX
61640		N	Dilate ic vasospasm, init	12.32	NA	4.50	0.66	000
61641		N	Dilate ic vasospasm add-on	4.33	NA	1.58	0.23	ZZZ
61642		N	Dilate ic vasospasm add-on	8.66	NA	3.16	0.46	ZZZ
61680		A	Intracranial vessel surgery	32.40	NA	19.95	8.81	090
61682		A	Intracranial vessel surgery	63.31	NA	33.40	17.21	090
61684		A	Intracranial vessel surgery	41.49	NA	24.35	11.28	090
61686		A	Intracranial vessel surgery	67.32	NA	36.85	18.30	090
61690		A	Intracranial vessel surgery	31.18	NA	19.39	8.48	090
61692		A	Intracranial vessel surgery	54.43	NA	30.31	14.80	090
61697		A	Brain aneurysm repr, complx	63.22	NA	34.47	17.00	090
61698		A	Brain aneurysm repr, complx	69.45	NA	37.85	18.88	090
61700		A	Brain aneurysm repr, simple	50.44	NA	28.76	13.61	090
61702		A	Inner skull vessel surgery	59.86	NA	33.35	16.27	090
61703		A	Clamp neck artery	18.70	NA	12.78	5.08	090
61705		A	Revise circulation to head	37.97	NA	22.29	10.32	090

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61708		A	Revise circulation to head	37.07	NA	15.83	2.31	090
61710		A	Revise circulation to head	31.19	NA	13.91	5.32	090
61711		A	Fusion of skull arteries	38.10	NA	21.85	10.36	090
61720		A	Incise skull/brain surgery	17.52	NA	11.89	4.76	090
61735		A	Incise skull/brain surgery	22.22	NA	14.57	6.04	090
61750		A	Incise skull/brain biopsy	19.73	NA	12.82	5.34	090
61751		A	Brain biopsy w/ct/mr guide	18.64	NA	13.11	4.99	090
61760		A	Implant brain electrodes	22.24	NA	14.29	6.05	090
61770		A	Incise skull for treatment	23.09	NA	13.99	6.17	090
61790		A	Treat trigeminal nerve	11.50	NA	8.78	3.10	090
61791		A	Treat trigeminal tract	15.31	NA	10.11	3.93	090
61795		A	Brain surgery using computer	4.03	NA	1.88	0.74	ZZZ
61796		A	Srs, cranial lesion simple	10.79	NA	7.68	2.71	090
61797		A	Srs, cran les simple, addl	3.48	NA	1.56	0.86	ZZZ
61798		A	Srs, cranial lesion complex	10.79	NA	7.68	2.71	090
61799		A	Srs, cran les complex, addl	4.81	NA	2.15	1.18	ZZZ
61800		A	Apply srs headframe add-on	2.25	NA	1.26	0.55	ZZZ
61850		A	Implant neuroelectrodes	13.26	NA	9.49	3.61	090
61860		A	Implant neuroelectrodes	22.16	NA	14.07	6.02	090
61863		A	Implant neuroelectrode	20.56	NA	14.20	5.58	090
61864		A	Implant neuroelecrde, addl	4.49	NA	2.11	1.22	ZZZ
61867		A	Implant neuroelectrode	32.88	NA	19.98	8.93	090
61868		A	Implant neuroelecrde, add/El	7.91	NA	3.72	2.12	ZZZ
61870		A	Implant neuroelectrodes	16.24	NA	11.16	4.42	090
61875		A	Implant neuroelectrodes	16.36	NA	7.66	0.88	090
61880		A	Revise/remove neuroelectrode	6.87	NA	6.36	1.85	090
61885		A	Insrt/redo neurostim 1 array	7.37	NA	8.26	1.90	090
61886		A	Implant neurostim arrays	9.73	NA	9.78	2.61	090
61888		A	Revise/remove neuroreceiver	5.20	NA	3.93	1.27	010
62000		A	Treat skull fracture	13.83	NA	10.03	1.00	090
62005		A	Treat skull fracture	17.53	NA	11.90	4.77	090
62010		A	Treatment of head injury	21.30	NA	14.14	5.79	090
62100		A	Repair brain fluid leakage	23.40	NA	14.51	5.63	090
62115		A	Reduction of skull defect	22.71	NA	10.81	1.22	090
62116		A	Reduction of skull defect	24.90	NA	16.16	6.77	090
62117		A	Reduction of skull defect	28.26	NA	15.49	2.76	090
62120		A	Repair skull cavity lesion	24.39	NA	19.27	2.38	090
62121		A	Incise skull repair	22.93	NA	19.84	6.23	090
62140		A	Repair of skull defect	14.45	NA	9.97	3.54	090
62141		A	Repair of skull defect	15.97	NA	10.89	4.01	090
62142		A	Remove skull plate/flap	11.73	NA	8.96	3.05	090
62143		A	Replace skull plate/flap	14.05	NA	10.09	3.75	090
62145		A	Repair of skull & brain	19.99	NA	12.59	5.43	090
62146		A	Repair of skull with graft	17.18	NA	11.73	4.67	090
62147		A	Repair of skull with graft	20.57	NA	13.32	5.59	090
62148		A	Retr bone flap to fix skull	2.00	NA	0.94	0.54	ZZZ
62160		A	Neuroendoscopy add-on	3.00	NA	1.40	0.80	ZZZ
62161		A	Dissect brain w/scope	21.10	NA	14.14	5.74	090
62162		A	Remove colloid cyst w/scope	26.67	NA	17.09	7.25	090
62163		A	Neuroendoscopy w/fb removal	16.40	NA	11.94	4.46	090
62164		A	Remove brain tumor w/scope	29.27	NA	19.09	7.96	090
62165		A	Remove pituit tumor w/scope	23.10	NA	14.48	4.92	090
62180		A	Establish brain cavity shunt	22.45	NA	14.58	6.10	090
62190		A	Establish brain cavity shunt	12.07	NA	9.33	3.28	090
62192		A	Establish brain cavity shunt	13.25	NA	9.62	3.46	090
62194		A	Replace/irrigate catheter	5.68	NA	5.16	1.54	010
62200		A	Establish brain cavity shunt	19.19	NA	12.68	5.22	090
62201		A	Brain cavity shunt w/scope	15.89	NA	11.96	4.30	090
62220		A	Establish brain cavity shunt	14.00	NA	9.72	3.66	090
62223		A	Establish brain cavity shunt	13.90	NA	10.70	3.64	090
62225		A	Replace/irrigate catheter	6.11	NA	5.99	1.63	090
62230		A	Replace/revise brain shunt	11.35	NA	8.29	2.98	090
62252		A	Csf shunt reprogram	0.74	1.82	NA	0.18	XXX
62252	TC	A	Csf shunt reprogram	0.00	1.47	NA	0.00	XXX
62252	26	A	Csf shunt reprogram	0.74	0.35	0.35	0.18	XXX
62256		A	Remove brain cavity shunt	7.30	NA	6.57	1.97	090
62258		A	Replace brain cavity shunt	15.54	NA	10.69	4.12	090
62263		A	Epidural lysis mult sessions	6.04	12.41	4.17	0.40	010
62264		A	Epidural lysis on single day	4.42	6.77	2.08	0.28	010
62267		A	Interdiscal perg aspir, dx	3.00	4.24	1.50	0.23	000
62268		A	Drain spinal cord cyst	4.73	5.79	1.92	0.35	000
62269		A	Needle biopsy, spinal cord	5.01	5.57	1.69	0.45	000
62270		A	Spinal fluid tap, diagnostic	1.37	2.46	0.60	0.11	000
62272		A	Drain cerebro spinal fluid	1.35	3.54	0.71	0.19	000
62273		A	Inject epidural patch	2.15	2.25	0.84	0.15	000
62280		A	Treat spinal cord lesion	2.63	5.35	1.46	0.39	010
62281		A	Treat spinal cord lesion	2.66	5.19	1.48	0.17	010
62282		A	Treat spinal canal lesion	2.33	5.02	1.46	0.20	010
62284		A	Injection for myelogram	1.54	3.59	0.67	0.13	000
62287		A	Percutaneous diskectomy	8.88	NA	5.29	0.63	090
62290		A	Inject for spine disk x-ray	3.00	5.59	1.56	0.23	000
62291		A	Inject for spine disk x-ray	2.91	5.32	1.52	0.21	000
62292		A	Injection into disk lesion	9.14	NA	4.20	0.59	090
62294		A	Injection into spinal artery	12.77	NA	3.32	0.92	090

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[4] Global totals for malpractice RVUs may not sum due to rounding.

CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
62310		A	Inject spine c/t	1.91	4.28	0.96	0.12	000
62311		A	Inject spine l/s (cd)	1.54	3.64	0.79	0.10	000
62318		A	Inject spine w/cath, c/t	2.04	3.98	0.63	0.12	000
62319		A	Inject spine w/cath l/s (cd)	1.87	3.77	0.68	0.12	000
62350		A	Implant spinal canal cath	1.29	NA	2.15	0.93	010
62351		A	Implant spinal canal cath	11.54	NA	9.43	2.54	090
62355		A	Remove spinal canal catheter	4.30	NA	3.38	0.64	010
62360		A	Insert spine infusion device	4.28	NA	3.47	0.72	010
62361		A	Implant spine infusion pump	5.60	NA	4.22	0.86	010
62362		A	Implant spine infusion pump	6.05	NA	4.29	1.06	010
62365		A	Remove spine infusion device	4.60	NA	3.67	0.77	010
62367		A	Analyze spine infusion pump	0.48	0.62	0.20	0.03	XXX
62368		A	Analyze spine infusion pump	0.75	0.86	0.31	0.05	XXX
63001		A	Removal of spinal lamina	17.51	NA	11.57	4.28	090
63003		A	Removal of spinal lamina	17.64	NA	11.65	4.24	090
63005		A	Removal of spinal lamina	16.28	NA	11.77	3.82	090
63011		A	Removal of spinal lamina	15.78	NA	10.88	3.02	090
63012		A	Removal of spinal lamina	16.72	NA	11.57	3.84	090
63015		A	Removal of spinal lamina	20.70	NA	14.01	5.27	090
63016		A	Removal of spinal lamina	21.90	NA	14.06	5.04	090
63017		A	Removal of spinal lamina	17.18	NA	12.25	4.20	090
63020		A	Neck spine disk surgery	16.05	NA	11.67	3.82	090
63030		A	Low back disk surgery	13.03	NA	10.13	2.91	090
63035		A	Spinal disk surgery add-on	3.15	NA	1.52	0.67	ZZZ
63040		A	Laminotomy, single cervical	20.18	NA	13.23	4.74	090
63042		A	Laminotomy, single lumbar	18.61	NA	12.74	3.91	090
63043		C	Laminotomy, add£l cervical	0.00	NA	0.00	0.00	ZZZ
63044		C	Laminotomy, add£l lumbar	0.00	NA	0.00	0.00	ZZZ
63045		A	Removal of spinal lamina	17.82	NA	12.20	4.30	090
63046		A	Removal of spinal lamina	17.12	NA	11.77	3.87	090
63047		A	Removal of spinal lamina	15.22	NA	11.15	3.30	090
63048		A	Remove spinal lamina add-on	3.47	NA	1.67	0.75	ZZZ
63050		A	Cervical laminoplasty	21.88	NA	14.11	5.95	090
63051		A	C-laminoplasty w/graft/plate	25.38	NA	15.85	5.43	090
63055		A	Decompress spinal cord	23.42	NA	14.89	5.79	090
63056		A	Decompress spinal cord	21.73	NA	13.84	4.69	090
63057		A	Decompress spine cord add-on	5.25	NA	2.53	1.14	ZZZ
63064		A	Decompress spinal cord	26.09	NA	16.06	5.98	090
63066		A	Decompress spine cord add-on	3.26	NA	1.60	0.49	ZZZ
63075		A	Neck spine disk surgery	19.47	NA	13.11	4.61	090
63076		A	Neck spine disk surgery	4.04	NA	1.93	0.93	ZZZ
63077		A	Spine disk surgery, thorax	22.75	NA	13.67	4.44	090
63078		A	Spine disk surgery, thorax	3.28	NA	1.57	0.57	ZZZ
63081		A	Removal of vertebral body	25.97	NA	16.26	5.92	090
63082		A	Remove vertebral body add-on	4.36	NA	2.09	0.98	ZZZ
63085		A	Removal of vertebral body	29.34	NA	16.69	5.94	090
63086		A	Remove vertebral body add-on	3.19	NA	1.48	0.66	ZZZ
63087		A	Removal of vertebral body	37.38	NA	20.84	7.30	090
63088		A	Remove vertebral body add-on	4.32	NA	2.06	0.79	ZZZ
63090		A	Removal of vertebral body	30.78	NA	17.76	5.42	090
63091		A	Remove vertebral body add-on	3.03	NA	1.43	0.51	ZZZ
63101		A	Removal of vertebral body	33.92	NA	21.05	8.02	090
63102		A	Removal of vertebral body	33.92	NA	20.81	6.45	090
63103		A	Remove vertebral body add-on	4.82	NA	2.31	0.91	ZZZ
63170		A	Incise spinal cord tract(s)	22.08	NA	14.79	6.00	090
63172		A	Drainage of spinal cyst	19.66	NA	12.77	4.99	090
63173		A	Drainage of spinal cyst	24.18	NA	15.78	6.57	090
63180		A	Revise spinal cord ligaments	20.40	NA	10.44	5.55	090
63182		A	Revise spinal cord ligaments	22.69	NA	15.08	6.17	090
63185		A	Incise spinal column/nerves	16.36	NA	11.97	4.45	090
63190		A	Incise spinal column/nerves	18.76	NA	12.63	3.25	090
63191		A	Incise spinal column/nerves	18.79	NA	13.94	2.81	090
63194		A	Incise spinal column & cord	21.97	NA	12.97	2.14	090
63195		A	Incise spinal column & cord	21.54	NA	14.07	5.86	090
63196		A	Incise spinal column & cord	25.14	NA	11.22	1.35	090
63197		A	Incise spinal column & cord	23.95	NA	15.67	6.51	090
63198		A	Incise spinal column & cord	29.75	NA	13.10	1.59	090
63199		A	Incise spinal column & cord	31.32	NA	13.67	1.68	090
63200		A	Release of spinal cord	21.31	NA	14.18	5.70	090
63250		A	Revise spinal cord vessels	43.73	NA	25.00	11.89	090
63251		A	Revise spinal cord vessels	44.49	NA	25.75	12.10	090
63252		A	Revise spinal cord vessels	44.48	NA	25.75	12.09	090
63265		A	Excise intraspinal lesion	23.69	NA	15.36	6.11	090
63266		A	Excise intraspinal lesion	24.55	NA	15.76	6.34	090
63267		A	Excise intraspinal lesion	19.32	NA	13.18	4.72	090
63268		A	Excise intraspinal lesion	19.89	NA	13.80	5.41	090
63270		A	Excise intraspinal lesion	29.67	NA	18.40	8.07	090
63271		A	Excise intraspinal lesion	29.79	NA	18.32	7.95	090
63272		A	Excise intraspinal lesion	27.37	NA	17.13	7.19	090
63273		A	Excise intraspinal lesion	26.34	NA	16.83	7.16	090
63275		A	Biopsy/excise spinal tumor	25.73	NA	16.33	6.63	090
63276		A	Biopsy/excise spinal tumor	25.56	NA	16.16	6.55	090
63277		A	Biopsy/excise spinal tumor	22.26	NA	14.51	5.25	090
63278		A	Biopsy/excise spinal tumor	21.99	NA	14.79	5.98	090

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
63280		A	Biopsy/excise spinal tumor	30.14	NA	18.92	8.19	090
63281		A	Biopsy/excise spinal tumor	29.84	NA	18.65	8.04	090
63282		A	Biopsy/excise spinal tumor	28.00	NA	17.84	7.52	090
63283		A	Biopsy/excise spinal tumor	26.61	NA	17.36	7.23	090
63285		A	Biopsy/excise spinal tumor	37.90	NA	22.58	10.30	090
63286		A	Biopsy/excise spinal tumor	37.47	NA	22.33	9.92	090
63287		A	Biopsy/excise spinal tumor	39.93	NA	23.61	10.86	090
63290		A	Biopsy/excise spinal tumor	40.67	NA	23.96	11.06	090
63295		A	Repair of laminectomy defect	5.25	NA	2.46	1.43	ZZZ
63300		A	Removal of vertebral body	26.67	NA	16.53	6.63	090
63301		A	Removal of vertebral body	31.42	NA	19.62	8.54	090
63302		A	Removal of vertebral body	31.00	NA	19.42	8.43	090
63303		A	Removal of vertebral body	33.42	NA	18.40	9.09	090
63304		A	Removal of vertebral body	33.70	NA	20.69	9.16	090
63305		A	Removal of vertebral body	36.09	NA	21.81	9.81	090
63306		A	Removal of vertebral body	35.40	NA	13.70	6.29	090
63307		A	Removal of vertebral body	34.81	NA	15.87	9.46	090
63308		A	Remove vertebral body add-on	5.24	NA	2.43	1.15	ZZZ
63600		A	Remove spinal cord lesion	15.02	NA	6.86	0.91	090
63610		A	Stimulation of spinal cord	8.72	14.04	1.68	2.37	000
63615		A	Remove lesion of spinal cord	17.22	NA	8.55	4.68	090
63620		A	Srs, spinal lesion	10.79	NA	7.68	2.71	090
63621		A	Srs, spinal lesion, addl	4.00	NA	1.79	0.98	ZZZ
63650		A	Implant neuroelectrodes	4.18	NA	3.11	0.50	010
63655		A	Implant neuroelectrodes	11.43	NA	9.02	2.73	090
63660		A	Revise/remove neuroelectrode	6.87	NA	4.89	0.85	090
63685		A	Insrt/redo spine n generator	4.27	NA	3.43	0.93	010
63688		A	Revise/remove neuroreceiver	5.25	NA	3.96	0.85	010
63700		A	Repair of spinal herniation	17.32	NA	12.71	4.71	090
63702		A	Repair of spinal herniation	19.26	NA	13.62	5.24	090
63704		A	Repair of spinal herniation	22.23	NA	15.89	6.04	090
63706		A	Repair of spinal herniation	25.15	NA	17.26	6.84	090
63707		A	Repair spinal fluid leakage	12.52	NA	9.37	2.64	090
63709		A	Repair spinal fluid leakage	15.52	NA	10.88	3.36	090
63710		A	Graft repair of spine defect	15.27	NA	10.92	3.68	090
63740		A	Install spinal shunt	12.50	NA	9.59	3.21	090
63741		A	Install spinal shunt	9.02	NA	5.71	1.65	090
63744		A	Revision of spinal shunt	8.86	NA	6.91	2.22	090
63746		A	Removal of spinal shunt	7.25	NA	6.67	1.97	090
64400		A	N block inj, trigeminal	1.11	1.85	0.65	0.08	000
64402		A	N block inj, facial	1.25	1.78	0.73	0.09	000
64405		A	N block inj, occipital	1.32	1.64	0.74	0.09	000
64408		A	N block inj, vagus	1.41	1.77	0.96	0.09	000
64410		A	N block inj, phrenic	1.43	2.42	0.66	0.25	000
64412		A	N block inj, spinal accessor	1.18	2.90	0.79	0.07	000
64413		A	N block inj, cervical plexus	1.40	1.64	0.66	0.09	000
64415		A	N block inj, brachial plexus	1.48	1.76	0.41	0.09	000
64416		A	N block cont infuse, b plex	1.81	NA	0.30	0.11	000
64417		A	N block inj, axillary	1.44	1.77	0.41	0.09	000
64418		A	N block inj, suprascapular	1.32	2.28	0.68	0.08	000
64420		A	N block inj, intercost, sng	1.18	3.07	0.63	0.09	000
64421		A	N block inj, intercost, mlt	1.68	4.58	0.79	0.15	000
64425		A	N block inj, ilio-ing/hypogi	1.75	1.74	0.79	0.14	000
64430		A	N block inj, pudendal	1.46	1.94	0.66	0.11	000
64435		A	N block inj, paracervical	1.45	1.93	0.70	0.10	000
64445		A	N block inj, sciatic, sng	1.48	1.95	0.64	0.09	000
64446		A	N blk inj, sciatic, cont inf	1.81	NA	0.33	0.12	000
64447		A	N block inj fem, single	1.50	NA	0.25	0.09	000
64448		A	N block inj fem, cont inf	1.63	NA	0.27	0.10	000
64449		A	N block inj, lumbar plexus	1.81	NA	0.37	0.11	000
64450		A	N block, other peripheral	1.27	1.44	0.55	0.08	000
64455		A	N block inj, plantar digit	0.75	0.60	0.27	0.06	000
64470		A	Inj paravertebral c/t	1.85	4.94	1.04	0.13	000
64472		A	Inj paravertebral c/t add-on	1.29	1.72	0.56	0.09	ZZZ
64475		A	Inj paravertebral l/s	1.41	4.82	0.86	0.10	000
64476		A	Inj paravertebral l/s add-on	0.98	1.55	0.39	0.07	ZZZ
64479		A	Inj foramen epidural c/t	2.20	5.09	1.23	0.18	000
64480		A	Inj foramen epidural add-on	1.54	2.19	0.65	0.18	ZZZ
64483		A	Inj foramen epidural l/s	1.90	5.12	1.11	0.12	000
64484		A	Inj foramen epidural add-on	1.33	2.30	0.56	0.09	ZZZ
64505		A	N block, spenopalatine gangl	1.36	1.16	0.81	0.07	000
64508		A	N block, carotid sinus s/p	1.12	3.16	0.86	0.18	000
64510		A	N block, stellate ganglion	1.22	2.73	0.72	0.07	000
64517		A	N block inj, hypogas plxs	2.20	2.58	1.17	0.13	000
64520		A	N block, lumbar/thoracic	1.35	3.63	0.82	0.08	000
64530		A	N block inj, celiac pelus	1.58	3.46	0.90	0.10	000
64550		A	Apply neurostimulator	0.18	0.24	0.07	0.01	000
64553		A	Implant neuroelectrodes	2.33	3.07	1.78	0.20	010
64555		A	Implant neuroelectrodes	2.29	2.55	1.43	0.16	010
64560		A	Implant neuroelectrodes	2.38	2.63	1.51	0.13	010
64561		A	Implant neuroelectrodes	7.07	15.46	3.22	0.50	010
64565		A	Implant neuroelectrodes	1.78	2.87	1.53	0.11	010
64573		A	Implant neuroelectrodes	8.15	NA	6.33	1.82	090
64575		A	Implant neuroelectrodes	4.37	NA	3.21	0.35	090

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CPT[1,3] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
64577		A	Implant neuroelectrodes	4.64	NA	5.15	1.26	090
64580		A	Implant neuroelectrodes	4.14	NA	3.38	0.67	090
64581		A	Implant neuroelectrodes	14.15	NA	5.75	1.18	090
64585		A	Revise/remove neuroelectrode	2.08	4.06	1.59	0.18	010
64590		A	Instr/redo pn/gastr stimul	2.42	4.05	1.64	0.19	010
64595		A	Revise/rmv pn/gastr stimul	1.75	4.26	1.44	0.14	010
64600		A	Injection treatment of nerve	3.46	6.70	2.24	0.27	010
64605		A	Injection treatment of nerve	5.62	13.80	4.10	1.53	010
64610		A	Injection treatment of nerve	7.17	11.04	4.40	1.58	010
64612		A	Destroy nerve, face muscle	1.98	2.14	1.84	0.12	010
64613		A	Destroy nerve, neck muscle	1.98	1.92	1.60	0.15	010
64614		A	Destroy nerve, extrem musc	2.20	2.18	1.75	0.13	010
64620		A	Injection treatment of nerve	2.86	4.75	1.78	0.21	010
64622		A	Destr paravertebrl nerve l/s	3.02	5.87	2.06	0.18	010
64623		A	Destr paravertebral n add-on	0.99	2.35	0.41	0.06	ZZZ
64626		A	Destr paravertebrl nerve c/t	3.82	6.83	2.98	0.23	010
64627		A	Destr paravertebral n add-on	1.16	3.35	0.48	0.07	ZZZ
64630		A	Injection treatment of nerve	3.02	2.56	1.72	0.22	010
64632		A	N block inj, common digit	1.20	1.09	0.70	0.07	010
64640		A	Injection treatment of nerve	2.78	2.72	1.59	0.15	010
64650		A	Chemodenerv eccrine glands	0.70	1.14	0.35	0.04	000
64653		A	Chemodenerv eccrine glands	0.88	1.32	0.39	0.06	000
64680		A	Injection treatment of nerve	2.64	5.39	1.64	0.20	010
64681		A	Injection treatment of nerve	3.78	4.94	1.20	0.23	010
64702		A	Revise finger/toe nerve	6.10	NA	6.29	0.78	090
64704		A	Revise hand/foot nerve	4.61	NA	3.68	0.40	090
64708		A	Revise arm/leg nerve	7.36	NA	6.54	0.86	090
64712		A	Revision of sciatic nerve	7.98	NA	5.80	1.00	090
64713		A	Revision of arm nerve(s)	11.29	NA	7.80	1.80	090
64714		A	Revise low back nerve(s)	10.44	NA	7.18	1.36	090
64716		A	Revision of cranial nerve	6.86	NA	6.52	0.80	090
64718		A	Revise ulnar nerve at elbow	7.06	NA	7.39	1.09	090
64719		A	Revise ulnar nerve at wrist	4.89	NA	4.97	0.70	090
64721		A	Carpal tunnel surgery	4.84	5.61	5.55	0.72	090
64722		A	Relieve pressure on nerve(s)	4.74	NA	3.98	0.55	090
64726		A	Release foot/toe nerve	4.21	NA	2.95	0.29	090
64727		A	Internal nerve revision	3.10	NA	1.54	0.45	ZZZ
64732		A	Incision of brow nerve	4.81	NA	5.39	1.31	090
64734		A	Incision of cheek nerve	5.45	NA	6.09	1.48	090
64736		A	Incision of chin nerve	5.13	NA	5.94	1.39	090
64738		A	Incision of jaw nerve	6.26	NA	6.47	1.70	090
64740		A	Incision of tongue nerve	6.12	NA	5.70	0.60	090
64742		A	Incision of facial nerve	6.75	NA	6.00	0.35	090
64744		A	Incise nerve, back of head	5.64	NA	5.78	1.53	090
64746		A	Incise diaphragm nerve	6.46	NA	5.09	1.15	090
64752		A	Incision of vagus nerve	7.59	NA	4.50	1.35	090
64755		A	Incision of stomach nerves	14.97	NA	7.80	2.42	090
64760		A	Incision of vagus nerve	7.49	NA	5.16	1.21	090
64761		A	Incision of pelvis nerve	6.94	NA	4.63	0.75	090
64763		A	Incise hip/thigh nerve	7.46	NA	5.06	1.21	090
64766		A	Incise hip/thigh nerve	9.34	NA	6.06	0.68	090
64771		A	Sever cranial nerve	8.02	NA	6.09	0.78	090
64772		A	Incision of spinal nerve	7.74	NA	6.42	1.36	090
64774		A	Remove skin nerve lesion	5.70	NA	4.73	0.77	090
64776		A	Remove digit nerve lesion	5.52	NA	4.40	0.63	090
64778		A	Digit nerve surgery add-on	3.11	NA	1.53	0.47	ZZZ
64782		A	Remove limb nerve lesion	6.76	NA	4.91	0.68	090
64783		A	Limb nerve surgery add-on	3.71	NA	2.10	0.35	ZZZ
64784		A	Remove nerve lesion	10.49	NA	7.87	1.51	090
64786		A	Remove sciatic nerve lesion	16.12	NA	10.80	2.41	090
64787		A	Implant nerve end	4.29	NA	1.96	0.52	ZZZ
64788		A	Remove skin nerve lesion	5.14	NA	4.68	0.80	090
64790		A	Removal of nerve lesion	11.97	NA	8.48	2.06	090
64792		A	Removal of nerve lesion	15.71	NA	11.78	4.27	090
64795		A	Biopsy of nerve	3.01	NA	1.81	0.55	000
64802		A	Remove sympathetic nerves	10.24	NA	7.13	0.62	090
64804		A	Remove sympathetic nerves	15.78	NA	4.18	0.95	090
64809		A	Remove sympathetic nerves	14.61	NA	3.80	0.88	090
64818		A	Remove sympathetic nerves	11.24	NA	5.47	1.65	090
64820		A	Remove sympathetic nerves	10.64	NA	8.42	1.43	090
64821		A	Remove sympathetic nerves	9.19	NA	7.85	1.38	090
64822		A	Remove sympathetic nerves	9.19	NA	7.85	1.38	090
64823		A	Remove sympathetic nerves	10.80	NA	8.64	1.62	090
64831		A	Repair of digit nerve	9.74	NA	8.45	1.23	090
64832		A	Repair nerve add-on	5.65	NA	3.01	0.75	ZZZ
64834		A	Repair of hand or foot nerve	10.71	NA	7.99	1.38	090
64835		A	Repair of hand or foot nerve	11.60	NA	8.58	1.74	090
64836		A	Repair of hand or foot nerve	11.60	NA	8.58	1.74	090
64837		A	Repair nerve add-on	6.25	NA	3.55	0.94	ZZZ
64840		A	Repair of leg nerve	13.87	NA	5.56	0.75	090
64856		A	Repair/transpose nerve	14.94	NA	10.63	2.14	090
64857		A	Repair arm/leg nerve	15.69	NA	11.06	2.17	090
64858		A	Repair sciatic nerve	17.69	NA	11.67	2.65	090
64859		A	Nerve surgery	4.25	NA	2.09	0.64	ZZZ

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CPT[1,2]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
64861		A	Repair of arm nerves	20.74	NA	13.46	5.64	090
64862		A	Repair of low back nerves	20.94	NA	14.23	5.69	090
64864		A	Repair of facial nerve	13.31	NA	9.08	1.30	090
64865		A	Repair of facial nerve	15.96	NA	13.11	1.56	090
64866		A	Fusion of facial/other nerve	16.70	NA	16.31	1.63	090
64868		A	Fusion of facial/other nerve	14.80	NA	11.86	1.44	090
64870		A	Fusion of facial/other nerve	16.95	NA	10.21	3.01	090
64872		A	Subsequent repair of nerve	1.99	NA	1.13	0.19	ZZZ
64874		A	Repair & revise nerve add-on	2.98	NA	1.40	0.81	ZZZ
64876		A	Repair nerve/shorten bone	3.37	NA	2.01	0.50	ZZZ
64885		A	Nerve graft, head or neck	17.50	NA	11.20	1.71	090
64886		A	Nerve graft, head or neck	20.72	NA	12.76	2.02	090
64890		A	Nerve graft, hand or foot	16.11	NA	10.80	2.41	090
64891		A	Nerve graft, hand or foot	17.22	NA	11.44	2.58	090
64892		A	Nerve graft, arm or leg	15.61	NA	10.55	2.34	090
64893		A	Nerve graft, arm or leg	16.74	NA	11.20	1.21	090
64895		A	Nerve graft, hand or foot	20.26	NA	12.93	3.03	090
64896		A	Nerve graft, hand or foot	21.81	NA	15.48	5.93	090
64897		A	Nerve graft, arm or leg	19.25	NA	12.44	2.88	090
64898		A	Nerve graft, arm or leg	20.82	NA	13.50	3.12	090
64901		A	Nerve graft add-on	10.20	NA	6.09	1.53	ZZZ
64902		A	Nerve graft add-on	11.81	NA	7.05	1.77	ZZZ
64905		A	Nerve pedicle transfer	14.98	NA	11.47	2.24	090
64907		A	Nerve pedicle transfer	19.90	NA	9.17	1.07	090
64910		A	Nerve repair w/allograft	11.21	NA	9.64	1.47	090
64911		A	Neurorraphy w/vein autograft	14.21	NA	11.84	2.13	090
64999		C	Nervous system surgery	0.00	0.00	0.00	0.00	YYY
65091		A	Revise eye	7.13	NA	8.88	0.37	090
65093		A	Revise eye with implant	6.93	NA	8.90	0.38	090
65101		A	Removal of eye	8.10	NA	10.42	0.42	090
65103		A	Remove eye/insert implant	8.64	NA	10.71	0.46	090
65105		A	Remove eye/attach implant	9.70	NA	11.68	0.53	090
65110		A	Removal of eye	15.42	NA	15.38	1.00	090
65112		A	Remove eye/revise socket	18.18	NA	17.96	0.95	090
65114		A	Remove eye/revise socket	19.32	NA	18.64	1.00	090
65125		A	Revise ocular implant	3.18	7.97	4.15	0.17	090
65130		A	Insert ocular implant	8.22	NA	10.17	0.43	090
65135		A	Insert ocular implant	8.40	NA	10.28	0.44	090
65140		A	Attach ocular implant	9.23	NA	11.09	0.48	090
65150		A	Revise ocular implant	6.32	NA	8.22	0.33	090
65155		A	Reinsert ocular implant	9.87	NA	11.47	0.51	090
65175		A	Removal of ocular implant	7.22	NA	9.23	0.38	090
65205		A	Remove foreign body from eye	0.71	0.72	0.44	0.04	000
65210		A	Remove foreign body from eye	0.84	0.93	0.57	0.04	000
65220		A	Remove foreign body from eye	0.71	0.76	0.39	0.05	000
65222		A	Remove foreign body from eye	0.93	1.02	0.61	0.04	000
65235		A	Remove foreign body from eye	8.78	NA	9.21	0.46	090
65260		A	Remove foreign body from eye	12.29	NA	12.14	0.64	090
65265		A	Remove foreign body from eye	14.06	NA	13.49	0.74	090
65270		A	Repair of eye wound	1.92	4.62	1.70	0.09	010
65272		A	Repair of eye wound	4.49	7.92	4.42	0.23	090
65273		A	Repair of eye wound	5.03	NA	4.68	0.26	090
65275		A	Repair of eye wound	6.14	8.36	5.66	0.32	090
65280		A	Repair of eye wound	8.87	NA	8.23	0.47	090
65285		A	Repair of eye wound	14.43	NA	12.15	0.75	090
65286		A	Repair of eye wound	6.45	10.98	6.15	0.34	090
65290		A	Repair of eye socket wound	6.35	NA	6.11	0.33	090
65400		A	Removal of eye lesion	7.27	9.71	7.93	0.38	090
65410		A	Biopsy of cornea	1.47	2.13	1.24	0.07	000
65420		A	Removal of eye lesion	4.24	8.47	5.25	0.22	090
65426		A	Removal of eye lesion	5.93	10.27	6.24	0.31	090
65430		A	Corneal smear	1.47	1.48	1.22	0.07	000
65435		A	Curette/treat cornea	0.92	1.12	0.88	0.04	000
65436		A	Curette/treat cornea	4.72	5.11	4.74	0.25	090
65450		A	Treatment of corneal lesion	3.35	4.74	4.66	0.18	090
65600		A	Revision of cornea	4.07	5.74	4.58	0.22	090
65710		A	Corneal transplant	14.09	NA	14.06	0.73	090
65730		A	Corneal transplant	15.99	NA	15.35	0.83	090
65750		A	Corneal transplant	16.60	NA	15.07	0.86	090
65755		A	Corneal transplant	16.49	NA	15.00	0.86	090
65756		A	Corneal trnspl, endothelial	16.60	NA	13.96	0.89	090
65757		C	Prep corneal endo allograft	0.00	NA	0.00	0.00	ZZZ
65770		A	Revise cornea with implant	19.41	NA	16.73	1.03	090
65772		A	Correction of astigmatism	4.96	6.36	5.33	0.26	090
65775		A	Correction of astigmatism	6.73	NA	7.22	0.35	090
65780		A	Ocular reconst, transplant	10.43	NA	11.92	0.55	090
65781		A	Ocular reconst, transplant	17.84	NA	16.41	0.93	090
65782		A	Ocular reconst, transplant	15.16	NA	14.34	0.80	090
65800		A	Drainage of eye	1.91	1.92	1.51	0.09	000
65805		A	Drainage of eye	1.91	2.26	1.51	0.09	000
65810		A	Drainage of eye	5.67	NA	6.29	0.30	090
65815		A	Drainage of eye	5.85	9.96	6.24	0.31	090
65820		A	Relieve inner eye pressure	8.72	NA	10.22	0.45	090
65850		A	Incision of eye	11.24	NA	10.34	0.59	090

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CPT[1,2] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
65855		A	Laser surgery of eye	3.90	4.65	3.69	0.18	010
65860		A	Incise inner eye adhesions	3.56	4.32	3.01	0.19	090
65865		A	Incise inner eye adhesions	5.66	NA	6.34	0.29	090
65870		A	Incise inner eye adhesions	7.21	NA	7.75	0.38	090
65875		A	Incise inner eye adhesions	7.61	NA	8.32	0.40	090
65880		A	Incise inner eye adhesions	8.16	NA	8.63	0.42	090
65900		A	Remove eye lesion	12.26	NA	12.32	0.64	090
65920		A	Remove implant of eye	9.74	NA	10.22	0.51	090
65930		A	Remove blood clot from eye	8.24	NA	8.03	0.43	090
66020		A	Injection treatment of eye	1.61	3.01	1.73	0.07	010
66030		A	Injection treatment of eye	1.27	2.80	1.53	0.06	010
66130		A	Remove eye lesion	7.74	9.89	6.94	0.40	090
66150		A	Glaucoma surgery	10.18	NA	11.82	0.53	090
66155		A	Glaucoma surgery	10.17	NA	11.81	0.53	090
66160		A	Glaucoma surgery	12.04	NA	12.92	0.63	090
66165		A	Glaucoma surgery	9.89	NA	11.65	0.51	090
66170		A	Glaucoma surgery	14.57	NA	15.71	0.76	090
66172		A	Incision of eye	18.26	NA	19.88	0.95	090
66180		A	Implant eye shunt	16.02	NA	13.91	0.83	090
66185		A	Revise eye shunt	9.35	NA	9.68	0.49	090
66220		A	Repair eye lesion	8.98	NA	9.85	0.47	090
66225		A	Repair/graft eye lesion	12.38	NA	11.48	0.65	090
66250		A	Follow-up surgery of eye	6.92	11.64	7.20	0.36	090
66500		A	Incision of iris	3.75	NA	5.14	0.20	090
66505		A	Incision of iris	4.13	NA	5.61	0.21	090
66600		A	Remove iris and lesion	9.89	NA	11.17	0.51	090
66605		A	Removal of iris	13.99	NA	13.13	0.73	090
66625		A	Removal of iris	5.19	NA	5.70	0.27	090
66630		A	Removal of iris	7.10	NA	7.35	0.37	090
66635		A	Removal of iris	7.19	NA	7.40	0.37	090
66680		A	Repair iris & ciliary body	6.24	NA	6.85	0.33	090
66682		A	Repair iris & ciliary body	7.15	NA	8.87	0.37	090
66700		A	Destruction, ciliary body	5.06	6.34	5.01	0.26	090
66710		A	Ciliary transscleral therapy	5.06	6.11	5.00	0.27	090
66711		A	Ciliary endoscopic ablation	7.70	NA	8.53	0.40	090
66720		A	Destruction, ciliary body	4.86	6.91	5.72	0.28	090
66740		A	Destruction, ciliary body	5.06	6.04	5.01	0.26	090
66761		A	Revision of iris	4.87	6.54	5.62	0.25	090
66762		A	Revision of iris	5.25	6.71	5.56	0.27	090
66770		A	Removal of inner eye lesion	5.98	7.34	6.29	0.31	090
66820		A	Incision, secondary cataract	3.93	NA	5.92	0.20	090
66821		A	After cataract laser surgery	3.32	4.91	4.46	0.17	090
66825		A	Reposition intraocular lens	8.82	NA	10.36	0.46	090
66830		A	Removal of lens lesion	9.27	NA	8.93	0.48	090
66840		A	Removal of lens material	8.98	NA	8.77	0.47	090
66850		A	Removal of lens material	10.32	NA	9.90	0.54	090
66852		A	Removal of lens material	11.18	NA	10.41	0.58	090
66920		A	Extraction of lens	9.93	NA	9.36	0.52	090
66930		A	Extraction of lens	11.38	NA	10.52	0.59	090
66940		A	Extraction of lens	10.14	NA	9.80	0.53	090
66982		A	Cataract surgery, complex	14.83	NA	12.41	0.77	090
66983		A	Cataract surg w/iol, 1 stage	10.20	NA	8.82	0.53	090
66984		A	Cataract surg w/iol, 1 stage	10.36	NA	9.19	0.54	090
66985		A	Insert lens prosthesis	9.73	NA	9.83	0.51	090
66986		A	Exchange lens prosthesis	12.26	NA	11.36	0.64	090
66990		A	Ophthalmic endoscope add-on	1.51	NA	0.90	0.07	ZZZ
66999		C	Eye surgery procedure	0.00	0.00	0.00	0.00	YYY
67005		A	Partial removal of eye fluid	5.77	NA	6.22	0.30	090
67010		A	Partial removal of eye fluid	6.94	NA	6.91	0.36	090
67015		A	Release of eye fluid	7.00	NA	7.71	0.37	090
67025		A	Replace eye fluid	7.91	10.29	8.12	0.41	090
67027		A	Implant eye drug system	11.43	NA	10.42	0.60	090
67028		A	Injection eye drug	2.52	2.89	1.87	0.12	000
67030		A	Incise inner eye strands	5.91	NA	7.41	0.31	090
67031		A	Laser surgery, eye strands	4.34	5.41	4.66	0.23	090
67036		A	Removal of inner eye fluid	13.09	NA	11.54	0.68	090
67039		A	Laser treatment of retina	16.39	NA	15.15	0.85	090
67040		A	Laser treatment of retina	19.23	NA	17.13	1.00	090
67041		A	Vit for macular packer	19.00	NA	15.27	0.99	090
67042		A	Vit for macular hole	22.13	NA	17.14	1.15	090
67043		A	Vit for membrane dissect	22.94	NA	18.28	1.20	090
67101		A	Repair detached retina	8.60	11.13	8.55	0.45	090
67105		A	Repair detached retina	8.35	9.89	8.08	0.43	090
67107		A	Repair detached retina	16.35	NA	14.73	0.85	090
67108		A	Repair detached retina	22.49	NA	18.83	1.17	090
67110		A	Repair detached retina	10.02	11.90	9.71	0.52	090
67112		A	Rerepair detached retina	18.45	NA	15.68	0.96	090
67113		A	Repair retinal detach, cplx	25.00	NA	20.10	1.30	090
67115		A	Release encircling material	5.93	NA	6.66	0.31	090
67120		A	Remove eye implant material	6.92	9.52	7.21	0.36	090
67121		A	Remove eye implant material	12.00	NA	11.22	0.63	090
67141		A	Treatment of retina	6.00	7.21	6.36	0.31	090
67145		A	Treatment of retina	6.17	7.16	6.46	0.32	090
67208		A	Treatment of retinal lesion	7.50	7.76	7.26	0.39	090

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67210		A	Treatment of retinal lesion	9.35	8.42	7.89	0.49	090
67218		A	Treatment of retinal lesion	20.22	NA	15.82	1.05	090
67220		A	Treatment of choroid lesion	14.19	13.05	11.87	0.74	090
67221		R	Ocular photodynamic ther	3.45	3.92	2.21	0.16	000
67225		A	Eye photodynamic ther add-on	0.47	0.32	0.28	0.02	ZZZ
67227		A	Treatment of retinal lesion	7.38	8.13	7.19	0.38	090
67228		A	Treatment of retinal lesion	13.67	17.81	14.03	0.71	090
67229		A	Tr retinal les preterm inf	16.00	NA	13.50	0.83	090
67250		A	Reinforce eye wall	9.46	NA	10.40	0.49	090
67255		A	Reinforce/graft eye wall	9.97	NA	11.33	0.52	090
67299		C	Eye surgery procedure	0.00	0.00	0.00	0.00	YYY
67311		A	Revise eye muscle	7.59	NA	7.61	0.40	090
67312		A	Revise two eye muscles	9.48	NA	8.75	0.50	090
67314		A	Revise eye muscle	8.59	NA	8.53	0.45	090
67316		A	Revise two eye muscles	10.73	NA	9.73	0.57	090
67318		A	Revise eye muscle(s)	8.92	NA	9.04	0.46	090
67320		A	Revise eye muscle(s) add-on	5.40	NA	3.19	0.25	ZZZ
67331		A	Eye surgery follow-up add-on	5.13	NA	3.01	0.24	ZZZ
67332		A	Rerevise eye muscles add-on	5.56	NA	3.29	0.26	ZZZ
67334		A	Revise eye muscle w/suture	5.05	NA	3.00	0.23	ZZZ
67335		A	Eye suture during surgery	2.49	NA	1.47	0.12	ZZZ
67340		A	Revise eye muscle add-on	6.00	NA	3.56	0.28	ZZZ
67343		A	Release eye tissue	8.29	NA	8.30	0.45	090
67345		A	Destroy nerve of eye muscle	2.98	2.95	2.41	0.17	010
67346		A	Biopsy, eye muscle	2.87	NA	2.38	0.13	000
67399		C	Eye muscle surgery procedure	0.00	0.00	0.00	0.00	YYY
67400		A	Explore/biopsy eye socket	10.97	NA	12.56	0.63	090
67405		A	Explore/drain eye socket	9.00	NA	10.95	0.52	090
67412		A	Explore/treat eye socket	10.17	NA	11.46	0.58	090
67413		A	Explore/treat eye socket	10.09	NA	11.63	0.61	090
67414		A	Explr/decompress eye socket	17.78	NA	16.38	0.95	090
67415		A	Aspiration, orbital contents	1.76	NA	1.04	0.08	000
67420		A	Explore/treat eye socket	21.62	NA	19.81	1.25	090
67430		A	Explore/treat eye socket	14.99	NA	16.62	0.78	090
67440		A	Explore/drain eye socket	14.56	NA	16.04	0.76	090
67445		A	Explr/decompress eye socket	18.96	NA	17.13	1.05	090
67450		A	Explore/biopsy eye socket	15.11	NA	16.69	0.79	090
67500		A	Inject/treat eye socket	1.44	0.85	0.68	0.08	000
67505		A	Inject/treat eye socket	1.27	1.06	0.88	0.06	000
67515		A	Inject/treat eye socket	1.40	1.14	0.96	0.06	000
67550		A	Insert eye socket implant	11.52	NA	12.90	0.83	090
67560		A	Revise eye socket implant	11.93	NA	13.05	0.73	090
67570		A	Decompress optic nerve	14.21	NA	14.83	0.74	090
67599		C	Orbit surgery procedure	0.00	0.00	0.00	0.00	YYY
67700		A	Drainage of eyelid abscess	1.37	5.06	1.55	0.07	010
67710		A	Incision of eyelid	1.04	4.32	1.40	0.05	010
67715		A	Incision of eyelid fold	1.24	4.45	1.50	0.07	010
67800		A	Remove eyelid lesion	1.39	1.82	1.27	0.07	010
67801		A	Remove eyelid lesions	1.89	2.24	1.57	0.09	010
67805		A	Remove eyelid lesions	2.24	2.87	2.01	0.11	010
67808		A	Remove eyelid lesion(s)	4.47	NA	4.82	0.26	090
67810		A	Biopsy of eyelid	1.48	3.84	0.88	0.08	000
67820		A	Revise eyelashes	0.71	0.60	0.68	0.03	000
67825		A	Revise eyelashes	1.40	1.82	1.67	0.07	010
67830		A	Revise eyelashes	1.72	4.76	1.79	0.08	010
67835		A	Revise eyelashes	5.61	NA	5.62	0.29	090
67840		A	Remove eyelid lesion	2.06	4.70	2.00	0.10	010
67850		A	Treat eyelid lesion	1.71	3.60	1.75	0.09	010
67875		A	Closure of eyelid by suture	1.35	2.90	1.18	0.07	000
67880		A	Revision of eyelid	4.47	6.90	4.83	0.25	090
67882		A	Revision of eyelid	5.87	8.22	6.10	0.32	090
67900		A	Repair brow defect	6.69	9.36	6.31	0.44	090
67901		A	Repair eyelid defect	7.47	11.36	7.27	0.42	090
67902		A	Repair eyelid defect	9.68	NA	8.85	0.63	090
67903		A	Repair eyelid defect	6.42	8.53	6.00	0.37	090
67904		A	Repair eyelid defect	7.83	10.57	7.46	0.46	090
67906		A	Repair eyelid defect	6.84	NA	6.25	0.36	090
67908		A	Repair eyelid defect	5.19	7.19	5.60	0.28	090
67909		A	Revise eyelid defect	5.46	7.93	5.68	0.35	090
67911		A	Revise eyelid defect	7.38	NA	7.02	0.42	090
67912		A	Correction eyelid w/implant	6.23	15.41	6.25	0.45	090
67914		A	Repair eyelid defect	3.70	5.97	3.67	0.22	090
67915		A	Repair eyelid defect	3.21	5.38	3.26	0.21	090
67916		A	Repair eyelid defect	5.37	8.07	5.61	0.31	090
67917		A	Repair eyelid defect	6.08	8.61	6.04	0.36	090
67921		A	Repair eyelid defect	3.42	5.80	3.51	0.18	090
67922		A	Repair eyelid defect	3.09	5.22	3.15	0.22	090
67923		A	Repair eyelid defect	5.94	8.31	5.96	0.33	090
67924		A	Repair eyelid defect	5.84	8.82	5.65	0.32	090
67930		A	Repair eyelid wound	3.62	5.55	2.66	0.20	010
67935		A	Repair eyelid wound	6.27	8.64	5.13	0.39	090
67938		A	Remove eyelid foreign body	1.35	4.53	1.58	0.07	010
67950		A	Revision of eyelid	5.88	8.45	5.93	0.37	090
67961		A	Revision of eyelid	5.75	8.64	5.85	0.34	090

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
67966		A	Revision of eyelid	8.83	10.61	8.05	0.52	090
67971		A	Reconstruction of eyelid	9.87	NA	8.76	0.54	090
67973		A	Reconstruction of eyelid	12.96	NA	11.10	0.75	090
67974		A	Reconstruction of eyelid	12.93	NA	11.06	0.70	090
67975		A	Reconstruction of eyelid	9.21	NA	8.39	0.54	090
67999		C	Revision of eyelid	0.00	0.00	0.00	0.00	YYY
68020		A	Incise/drain eyelid lining	1.39	1.62	1.41	0.06	010
68040		A	Treatment of eyelid lesions	0.85	0.82	0.54	0.04	000
68100		A	Biopsy of eyelid lining	1.35	2.85	1.20	0.07	000
68110		A	Remove eyelid lining lesion	1.79	3.76	1.99	0.08	010
68115		A	Remove eyelid lining lesion	2.38	5.28	2.34	0.11	010
68130		A	Remove eyelid lining lesion	4.99	8.39	5.47	0.26	090
68135		A	Remove eyelid lining lesion	1.86	2.12	1.99	0.09	010
68200		A	Treat eyelid by injection	0.49	0.59	0.42	0.02	000
68320		A	Revise/graft eyelid lining	6.44	11.45	7.16	0.36	090
68325		A	Revise/graft eyelid lining	8.43	NA	8.31	0.49	090
68326		A	Revise/graft eyelid lining	8.22	NA	8.19	0.44	090
68328		A	Revise/graft eyelid lining	9.25	NA	8.86	0.61	090
68330		A	Revise eyelid lining	5.63	9.37	6.05	0.32	090
68335		A	Revise/graft eyelid lining	8.26	NA	8.24	0.45	090
68340		A	Separate eyelid adhesions	4.84	8.62	5.27	0.25	090
68360		A	Revise eyelid lining	5.04	8.14	5.38	0.28	090
68362		A	Revise eyelid lining	8.41	NA	8.27	0.44	090
68371		A	Harvest eye tissue, alograft	4.97	NA	5.50	0.23	010
68399		C	Eyelid lining surgery	0.00	0.00	0.00	0.00	YYY
68400		A	Incise/drain tear gland	1.71	5.17	1.66	0.08	010
68420		A	Incise/drain tear sac	2.32	5.54	2.02	0.12	010
68440		A	Incise tear duct opening	0.96	1.57	1.50	0.05	010
68500		A	Removal of tear gland	12.49	NA	12.36	0.65	090
68505		A	Partial removal, tear gland	12.41	NA	12.31	0.65	090
68510		A	Biopsy of tear gland	4.60	6.65	3.11	0.23	000
68520		A	Removal of tear sac	8.58	NA	8.87	0.50	090
68525		A	Biopsy of tear sac	4.42	NA	2.62	0.22	000
68530		A	Clearance of tear duct	3.67	6.93	3.01	0.18	010
68540		A	Remove tear gland lesion	11.93	NA	11.77	0.62	090
68550		A	Remove tear gland lesion	14.86	NA	12.39	1.45	090
68700		A	Repair tear ducts	7.67	NA	7.68	0.43	090
68705		A	Revise tear duct opening	2.08	3.78	2.17	0.10	010
68720		A	Create tear sac drain	9.78	NA	9.51	0.56	090
68745		A	Create tear duct drain	9.70	NA	9.68	0.50	090
68750		A	Create tear duct drain	9.87	NA	10.13	0.58	090
68760		A	Close tear duct opening	1.75	3.22	1.96	0.08	010

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
68761		A	Close tear duct opening	1.38	2.29	1.63	0.06	010
68770		A	Close tear system fistula	8.09	NA	7.92	0.42	090
68801		A	Dilate tear duct opening	0.96	2.13	1.73	0.05	010
68810		A	Probe nasolacrimal duct	2.09	3.88	2.61	0.10	010
68811		A	Probe nasolacrimal duct	2.39	NA	2.82	0.12	010
68815		A	Probe nasolacrimal duct	3.24	7.75	3.32	0.16	010
68816		A	Probe nl duct w/balloon	3.00	14.79	3.38	0.16	010
68840		A	Explore/irrigate tear ducts	1.27	1.92	1.66	0.06	010
68850		A	Injection for tear sac x-ray	0.80	0.77	0.65	0.05	000
68899		C	Tear duct system surgery	0.00	0.00	0.00	0.00	YYY
69000		A	Drain external ear lesion	1.47	3.21	1.58	0.10	010
69005		A	Drain external ear lesion	2.13	3.33	1.92	0.15	010
69020		A	Drain outer ear canal lesion	1.50	4.43	2.17	0.10	010
69100		A	Biopsy of external ear	0.81	1.72	0.48	0.05	000
69105		A	Biopsy of external ear canal	0.85	2.73	0.82	0.05	000
69110		A	Remove external ear, partial	3.47	8.04	4.79	0.40	090
69120		A	Removal of external ear	4.08	NA	6.25	0.43	090
69140		A	Remove ear canal lesion(s)	8.03	NA	14.42	0.78	090
69145		A	Remove ear canal lesion(s)	2.65	7.41	3.76	0.26	090
69150		A	Extensive ear canal surgery	13.49	NA	13.51	1.47	090
69155		A	Extensive ear/neck surgery	23.06	NA	20.32	2.25	090
69200		A	Clear outer ear canal	0.77	2.37	0.73	0.05	000
69205		A	Clear outer ear canal	1.20	NA	1.42	0.08	010
69210		A	Remove impacted ear wax	0.61	0.71	0.26	0.04	000
69220		A	Clean out mastoid cavity	0.83	2.69	0.80	0.05	000
69222		A	Clean out mastoid cavity	1.42	4.17	2.10	0.09	010
69300		R	Revise external ear	6.69	11.19	5.81	0.44	YYY
69310		A	Rebuild outer ear canal	10.85	NA	16.99	1.07	090
69320		A	Rebuild outer ear canal	17.03	NA	22.47	1.66	090
69399		C	Outer ear surgery procedure	0.00	0.00	0.00	0.00	YYY
69400		A	Inflate middle ear canal	0.83	2.94	0.80	0.05	000
69401		A	Inflate middle ear canal	0.63	1.60	0.66	0.04	000
69405		A	Catheterize middle ear canal	2.65	4.08	2.36	0.17	010
69420		A	Incision of eardrum	1.35	3.52	1.75	0.09	010
69421		A	Incision of eardrum	1.75	NA	2.10	0.11	010
69424		A	Remove ventilating tube	0.85	2.44	0.79	0.06	000
69433		A	Create eardrum opening	1.54	3.54	1.81	0.10	010
69436		A	Create eardrum opening	1.98	NA	2.18	0.13	010
69440		A	Exploration of middle ear	7.62	NA	10.20	0.74	090
69450		A	Eardrum revision	5.61	NA	8.42	0.55	090
69501		A	Mastoidectomy	9.12	NA	9.91	0.89	090
69502		A	Mastoidectomy	12.44	NA	12.71	1.27	090

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
69505		A	Remove mastoid structures	13.05	NA	17.99	1.27	090
69511		A	Extensive mastoid surgery	13.58	NA	18.28	1.32	090
69530		A	Extensive mastoid surgery	20.24	NA	22.70	1.97	090
69535		A	Remove part of temporal bone	37.27	NA	32.17	3.95	090
69540		A	Remove ear lesion	1.22	4.08	2.03	0.08	010
69550		A	Remove ear lesion	11.04	NA	15.81	1.08	090
69552		A	Remove ear lesion	19.69	NA	21.15	1.92	090
69554		A	Remove ear lesion	35.71	NA	28.81	3.48	090
69601		A	Mastoid surgery revision	13.31	NA	13.92	1.30	090
69602		A	Mastoid surgery revision	13.64	NA	14.70	1.33	090
69603		A	Mastoid surgery revision	14.08	NA	18.51	1.37	090
69604		A	Mastoid surgery revision	14.08	NA	14.90	1.37	090
69605		A	Mastoid surgery revision	18.55	NA	21.91	1.81	090
69610		A	Repair of eardrum	4.44	5.54	3.21	0.29	010
69620		A	Repair of eardrum	5.94	11.75	6.67	0.58	090
69631		A	Repair eardrum structures	9.93	NA	12.93	0.97	090
69632		A	Rebuild eardrum structures	12.82	NA	15.13	1.25	090
69633		A	Rebuild eardrum structures	12.17	NA	14.83	1.20	090
69635		A	Repair eardrum structures	13.39	NA	18.06	1.32	090
69636		A	Rebuild eardrum structures	15.29	NA	20.38	1.49	090
69637		A	Rebuild eardrum structures	15.18	NA	20.18	1.49	090
69641		A	Revise middle ear & mastoid	12.77	NA	14.27	1.26	090
69642		A	Revise middle ear & mastoid	16.91	NA	17.90	1.65	090
69643		A	Revise middle ear & mastoid	15.45	NA	16.36	1.52	090
69644		A	Revise middle ear & mastoid	17.09	NA	21.19	1.68	090
69645		A	Revise middle ear & mastoid	16.57	NA	20.97	1.63	090
69646		A	Revise middle ear & mastoid	18.23	NA	21.77	1.78	090
69650		A	Release middle ear bone	9.71	NA	11.18	0.95	090
69660		A	Revise middle ear bone	11.94	NA	12.20	1.17	090
69661		A	Revise middle ear bone	15.80	NA	15.59	1.51	090
69662		A	Revise middle ear bone	15.49	NA	14.67	1.52	090
69666		A	Repair middle ear structures	9.80	NA	11.17	0.96	090
69667		A	Repair middle ear structures	9.81	NA	11.17	0.96	090
69670		A	Remove mastoid air cells	11.62	NA	12.92	1.13	090
69676		A	Remove middle ear nerve	9.58	NA	11.96	0.93	090
69700		A	Close mastoid fistula	8.28	NA	9.52	0.81	090
69711		A	Remove/repair hearing aid	10.50	NA	11.89	1.02	090
69714		A	Implant temple bone w/stimul	14.31	NA	13.71	1.40	090
69715		A	Temple bne implnt w/stimulat	18.80	NA	15.98	1.83	090
69717		A	Temple bone implant revision	15.29	NA	14.20	1.49	090
69718		A	Revise temple bone implant	19.05	NA	16.10	1.86	090
69720		A	Release facial nerve	14.57	NA	15.95	1.59	090

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69725		A	Release facial nerve	27.44	NA	21.90	2.68	090
69740		A	Repair facial nerve	16.18	NA	14.41	1.58	090
69745		A	Repair facial nerve	16.91	NA	15.59	1.65	090
69799		C	Middle ear surgery procedure	0.00	0.00	0.00	0.00	YYY
69801		A	Incise inner ear	8.61	NA	10.85	0.84	090
69802		A	Incise inner ear	13.39	NA	13.75	1.31	090
69805		A	Explore inner ear	14.55	NA	12.97	1.42	090
69806		A	Explore inner ear	12.52	NA	12.13	1.22	090
69820		A	Establish inner ear window	10.40	NA	11.84	1.01	090
69840		A	Revise inner ear window	10.32	NA	14.44	0.54	090
69905		A	Remove inner ear	11.15	NA	12.70	1.09	090
69910		A	Remove inner ear & mastoid	13.80	NA	12.78	1.36	090
69915		A	Incise inner ear nerve	22.65	NA	14.35	2.23	090
69930		A	Implant cochlear device	17.60	NA	14.43	1.72	090
69949		C	Inner ear surgery procedure	0.00	0.00	0.00	0.00	YYY
69950		A	Incise inner ear nerve	27.44	NA	19.46	2.68	090
69955		A	Release facial nerve	29.22	NA	22.75	2.85	090
69960		A	Release inner ear canal	29.22	NA	21.40	2.85	090
69970		A	Remove inner ear lesion	32.21	NA	24.14	3.14	090
69979		C	Temporal bone surgery	0.00	0.00	0.00	0.00	YYY
69990		R	Microsurgery add-on	3.46	NA	1.62	0.85	ZZZ
70010		A	Contrast x-ray of brain	1.19	2.48	NA	0.18	XXX
70010	TC	A	Contrast x-ray of brain	0.00	2.12	NA	0.00	XXX
70010	26	A	Contrast x-ray of brain	1.19	0.36	0.36	0.17	XXX
70015		A	Contrast x-ray of brain	1.19	2.64	NA	0.09	XXX
70015	TC	A	Contrast x-ray of brain	0.00	2.26	NA	0.00	XXX
70015	26	A	Contrast x-ray of brain	1.19	0.38	0.38	0.08	XXX
70030		A	X-ray eye for foreign body	0.17	0.54	NA	0.01	XXX
70030	TC	A	X-ray eye for foreign body	0.00	0.49	NA	0.00	XXX
70030	26	A	X-ray eye for foreign body	0.17	0.05	0.05	0.01	XXX
70100		A	X-ray exam of jaw	0.18	0.59	NA	0.01	XXX
70100	TC	A	X-ray exam of jaw	0.00	0.54	NA	0.00	XXX
70100	26	A	X-ray exam of jaw	0.18	0.05	0.05	0.01	XXX
70110		A	X-ray exam of jaw	0.25	0.72	NA	0.02	XXX
70110	TC	A	X-ray exam of jaw	0.00	0.64	NA	0.00	XXX
70110	26	A	X-ray exam of jaw	0.25	0.08	0.08	0.01	XXX
70120		A	X-ray exam of mastoids	0.18	0.76	NA	0.01	XXX
70120	TC	A	X-ray exam of mastoids	0.00	0.69	NA	0.00	XXX
70120	26	A	X-ray exam of mastoids	0.18	0.07	0.07	0.01	XXX
70130		A	X-ray exam of mastoids	0.34	1.08	NA	0.02	XXX
70130	TC	A	X-ray exam of mastoids	0.00	0.97	NA	0.00	XXX
70130	26	A	X-ray exam of mastoids	0.34	0.11	0.11	0.02	XXX

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CPT[1,2] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
70134		A	X-ray exam of middle ear	0.34	0.81	NA	0.02	XXX
70134	TC	A	X-ray exam of middle ear	0.00	0.70	NA	0.00	XXX
70134	26	A	X-ray exam of middle ear	0.34	0.10	0.10	0.02	XXX
70140		A	X-ray exam of facial bones	0.19	0.49	NA	0.01	XXX
70140	TC	A	X-ray exam of facial bones	0.00	0.44	NA	0.00	XXX
70140	26	A	X-ray exam of facial bones	0.19	0.05	0.05	0.01	XXX
70150		A	X-ray exam of facial bones	0.26	0.76	NA	0.02	XXX
70150	TC	A	X-ray exam of facial bones	0.00	0.69	NA	0.00	XXX
70150	26	A	X-ray exam of facial bones	0.26	0.07	0.07	0.02	XXX
70160		A	X-ray exam of nasal bones	0.17	0.63	NA	0.01	XXX
70160	TC	A	X-ray exam of nasal bones	0.00	0.58	NA	0.00	XXX
70160	26	A	X-ray exam of nasal bones	0.17	0.05	0.05	0.01	XXX
70170		C	X-ray exam of tear duct	0.00	NA	NA	0.00	XXX
70170	TC	C	X-ray exam of tear duct	0.00	NA	NA	0.00	XXX
70170	26	A	X-ray exam of tear duct	0.30	0.09	0.09	0.02	XXX
70190		A	X-ray exam of eye sockets	0.21	0.64	NA	0.02	XXX
70190	TC	A	X-ray exam of eye sockets	0.00	0.58	NA	0.00	XXX
70190	26	A	X-ray exam of eye sockets	0.21	0.06	0.06	0.02	XXX
70200		A	X-ray exam of eye sockets	0.28	0.78	NA	0.02	XXX
70200	TC	A	X-ray exam of eye sockets	0.00	0.70	NA	0.00	XXX
70200	26	A	X-ray exam of eye sockets	0.28	0.08	0.08	0.02	XXX
70210		A	X-ray exam of sinuses	0.17	0.60	NA	0.01	XXX
70210	TC	A	X-ray exam of sinuses	0.00	0.54	NA	0.00	XXX
70210	26	A	X-ray exam of sinuses	0.17	0.06	0.06	0.01	XXX
70220		A	X-ray exam of sinuses	0.25	0.72	NA	0.01	XXX
70220	TC	A	X-ray exam of sinuses	0.00	0.63	NA	0.00	XXX
70220	26	A	X-ray exam of sinuses	0.25	0.08	0.08	0.01	XXX
70240		A	X-ray exam, pituitary saddle	0.19	0.53	NA	0.01	XXX
70240	TC	A	X-ray exam, pituitary saddle	0.00	0.47	NA	0.00	XXX
70240	26	A	X-ray exam, pituitary saddle	0.19	0.06	0.06	0.01	XXX
70250		A	X-ray exam of skull	0.24	0.62	NA	0.02	XXX
70250	TC	A	X-ray exam of skull	0.00	0.56	NA	0.00	XXX
70250	26	A	X-ray exam of skull	0.24	0.06	0.06	0.02	XXX
70260		A	X-ray exam of skull	0.34	0.78	NA	0.02	XXX
70260	TC	A	X-ray exam of skull	0.00	0.69	NA	0.00	XXX
70260	26	A	X-ray exam of skull	0.34	0.09	0.09	0.02	XXX
70300		A	X-ray exam of teeth	0.10	0.24	NA	0.00	XXX
70300	TC	A	X-ray exam of teeth	0.00	0.19	NA	0.00	XXX
70300	26	A	X-ray exam of teeth	0.10	0.05	0.05	0.00	XXX
70310		A	X-ray exam of teeth	0.16	0.81	NA	0.00	XXX
70310	TC	A	X-ray exam of teeth	0.00	0.72	NA	0.00	XXX
70310	26	A	X-ray exam of teeth	0.16	0.09	0.09	0.00	XXX
70320		A	Full mouth x-ray of teeth	0.22	1.03	NA	0.01	XXX
70320	TC	A	Full mouth x-ray of teeth	0.00	0.93	NA	0.00	XXX
70320	26	A	Full mouth x-ray of teeth	0.22	0.10	0.10	0.01	XXX
70328		A	X-ray exam of jaw joint	0.18	0.59	NA	0.01	XXX
70328	TC	A	X-ray exam of jaw joint	0.00	0.53	NA	0.00	XXX
70328	26	A	X-ray exam of jaw joint	0.18	0.06	0.06	0.01	XXX
70330		A	X-ray exam of jaw joints	0.24	0.95	NA	0.01	XXX
70330	TC	A	X-ray exam of jaw joints	0.00	0.86	NA	0.00	XXX
70330	26	A	X-ray exam of jaw joints	0.24	0.09	0.09	0.01	XXX
70332		A	X-ray exam of jaw joint	0.54	1.44	NA	0.01	XXX
70332	TC	A	X-ray exam of jaw joint	0.00	1.24	NA	0.00	XXX
70332	26	A	X-ray exam of jaw joint	0.54	0.20	0.20	0.01	XXX
70336		A	Magnetic image, jaw joint	1.48	6.64	NA	0.11	XXX
70336	TC	A	Magnetic image, jaw joint	0.00	6.19	NA	0.00	XXX
70336	26	A	Magnetic image, jaw joint	1.48	0.45	0.45	0.10	XXX
70350		A	X-ray head for orthodontia	0.17	0.36	NA	0.00	XXX
70350	TC	A	X-ray head for orthodontia	0.00	0.26	NA	0.00	XXX
70350	26	A	X-ray head for orthodontia	0.17	0.09	0.09	0.00	XXX
70355		A	Panoramic x-ray of jaws	0.20	0.30	NA	0.01	XXX
70355	TC	A	Panoramic x-ray of jaws	0.00	0.21	NA	0.00	XXX
70355	26	A	Panoramic x-ray of jaws	0.20	0.09	0.09	0.01	XXX
70360		A	X-ray exam of neck	0.17	0.52	NA	0.01	XXX
70360	TC	A	X-ray exam of neck	0.00	0.46	NA	0.00	XXX
70360	26	A	X-ray exam of neck	0.17	0.05	0.05	0.01	XXX
70370		A	Throat x-ray & fluoroscopy	0.32	1.80	NA	0.02	XXX
70370	TC	A	Throat x-ray & fluoroscopy	0.00	1.69	NA	0.00	XXX
70370	26	A	Throat x-ray & fluoroscopy	0.32	0.11	0.11	0.02	XXX
70371		A	Speech evaluation, complex	0.84	1.51	NA	0.04	XXX
70371	TC	A	Speech evaluation, complex	0.00	1.21	NA	0.00	XXX
70371	26	A	Speech evaluation, complex	0.84	0.30	0.30	0.04	XXX
70373		A	Contrast x-ray of larynx	0.44	1.67	NA	0.02	XXX
70373	TC	A	Contrast x-ray of larynx	0.00	1.52	NA	0.00	XXX
70373	26	A	Contrast x-ray of larynx	0.44	0.16	0.16	0.02	XXX
70380		A	X-ray exam of salivary gland	0.17	0.79	NA	0.01	XXX
70380	TC	A	X-ray exam of salivary gland	0.00	0.71	NA	0.00	XXX
70380	26	A	X-ray exam of salivary gland	0.17	0.08	0.08	0.00	XXX
70390		A	X-ray exam of salivary duct	0.38	2.09	NA	0.03	XXX
70390	TC	A	X-ray exam of salivary duct	0.00	1.97	NA	0.00	XXX
70390	26	A	X-ray exam of salivary duct	0.38	0.12	0.12	0.03	XXX
70450		A	Ct head/brain w/o dye	0.85	2.87	NA	0.06	XXX
70450	TC	A	Ct head/brain w/o dye	0.00	2.61	NA	0.00	XXX
70450	26	A	Ct head/brain w/o dye	0.85	0.26	0.26	0.06	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
70460		A	Ct head/brain w/dye	1.13	3.79	NA	0.08	XXX
70460	TC	A	Ct head/brain w/dye	0.00	3.44	NA	0.00	XXX
70460	26	A	Ct head/brain w/dye	1.13	0.35	0.35	0.07	XXX
70470		A	Ct head/brain w/o & w/dye	1.27	4.62	NA	0.09	XXX
70470	TC	A	Ct head/brain w/o & w/dye	0.00	4.23	NA	0.00	XXX
70470	26	A	Ct head/brain w/o & w/dye	1.27	0.39	0.39	0.08	XXX
70480		A	Ct orbit/ear/fossa w/o dye	1.28	4.98	NA	0.08	XXX
70480	TC	A	Ct orbit/ear/fossa w/o dye	0.00	4.57	NA	0.00	XXX
70480	26	A	Ct orbit/ear/fossa w/o dye	1.28	0.40	0.40	0.08	XXX
70481		A	Ct orbit/ear/fossa w/dye	1.38	5.83	NA	0.10	XXX
70481	TC	A	Ct orbit/ear/fossa w/dye	0.00	5.41	NA	0.00	XXX
70481	26	A	Ct orbit/ear/fossa w/dye	1.38	0.42	0.42	0.09	XXX
70482		A	Ct orbit/ear/fossa w/o&w/dye	1.45	6.59	NA	0.10	XXX
70482	TC	A	Ct orbit/ear/fossa w/o&w/dye	0.00	6.14	NA	0.00	XXX
70482	26	A	Ct orbit/ear/fossa w/o&w/dye	1.45	0.45	0.45	0.10	XXX
70486		A	Ct maxillofacial w/o dye	1.14	4.02	NA	0.07	XXX
70486	TC	A	Ct maxillofacial w/o dye	0.00	3.66	NA	0.00	XXX
70486	26	A	Ct maxillofacial w/o dye	1.14	0.36	0.36	0.07	XXX
70487		A	Ct maxillofacial w/dye	1.30	4.88	NA	0.09	XXX
70487	TC	A	Ct maxillofacial w/dye	0.00	4.49	NA	0.00	XXX
70487	26	A	Ct maxillofacial w/dye	1.30	0.40	0.40	0.09	XXX
70488		A	Ct maxillofacial w/o & w/dye	1.42	5.98	NA	0.10	XXX
70488	TC	A	Ct maxillofacial w/o & w/dye	0.00	5.55	NA	0.00	XXX
70488	26	A	Ct maxillofacial w/o & w/dye	1.42	0.44	0.44	0.09	XXX
70490		A	Ct soft tissue neck w/o dye	1.28	3.79	NA	0.09	XXX
70490	TC	A	Ct soft tissue neck w/o dye	0.00	3.40	NA	0.00	XXX
70490	26	A	Ct soft tissue neck w/o dye	1.28	0.39	0.39	0.09	XXX
70491		A	Ct soft tissue neck w/dye	1.38	4.69	NA	0.09	XXX
70491	TC	A	Ct soft tissue neck w/dye	0.00	4.26	NA	0.00	XXX
70491	26	A	Ct soft tissue neck w/dye	1.38	0.43	0.43	0.09	XXX
70492		A	Ct sft tsue nck w/o & w/dye	1.45	5.77	NA	0.10	XXX
70492	TC	A	Ct sft tsue nck w/o & w/dye	0.00	5.33	NA	0.00	XXX
70492	26	A	Ct sft tsue nck w/o & w/dye	1.45	0.45	0.45	0.10	XXX
70496		A	Ct angiography, head	1.75	9.83	NA	0.13	XXX
70496	TC	A	Ct angiography, head	0.00	9.30	NA	0.00	XXX
70496	26	A	Ct angiography, head	1.75	0.53	0.53	0.12	XXX
70498		A	Ct angiography, neck	1.75	9.77	NA	0.12	XXX
70498	TC	A	Ct angiography, neck	0.00	9.23	NA	0.00	XXX
70498	26	A	Ct angiography, neck	1.75	0.54	0.54	0.12	XXX
70540		A	Mri orbit/face/neck w/o dye	1.35	7.65	NA	0.10	XXX
70540	TC	A	Mri orbit/face/neck w/o dye	0.00	7.24	NA	0.00	XXX
70540	26	A	Mri orbit/face/neck w/o dye	1.35	0.42	0.42	0.09	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
70542		A	Mri orbit/face/neck w/dye	1.62	8.50	NA	0.12	XXX
70542	TC	A	Mri orbit/face/neck w/dye	0.00	8.00	NA	0.00	XXX
70542	26	A	Mri orbit/face/neck w/dye	1.62	0.50	0.50	0.11	XXX
70543		A	Mri orbt/fac/nck w/o & w/dye	2.15	10.37	NA	0.16	XXX
70543	TC	A	Mri orbt/fac/nck w/o & w/dye	0.00	9.71	NA	0.01	XXX
70543	26	A	Mri orbt/fac/nck w/o & w/dye	2.15	0.66	0.66	0.15	XXX
70544		A	Mr angiography head w/o dye	1.20	8.81	NA	0.09	XXX
70544	TC	A	Mr angiography head w/o dye	0.00	8.44	NA	0.00	XXX
70544	26	A	Mr angiography head w/o dye	1.20	0.37	0.37	0.08	XXX
70545		A	Mr angiography head w/dye	1.20	8.81	NA	0.09	XXX
70545	TC	A	Mr angiography head w/dye	0.00	8.44	NA	0.00	XXX
70545	26	A	Mr angiography head w/dye	1.20	0.37	0.37	0.08	XXX
70546		A	Mr angiograph head w/o&w/dye	1.80	13.34	NA	0.13	XXX
70546	TC	A	Mr angiograph head w/o&w/dye	0.00	12.78	NA	0.01	XXX
70546	26	A	Mr angiograph head w/o&w/dye	1.80	0.55	0.55	0.13	XXX
70547		A	Mr angiography neck w/o dye	1.20	8.79	NA	0.09	XXX
70547	TC	A	Mr angiography neck w/o dye	0.00	8.42	NA	0.00	XXX
70547	26	A	Mr angiography neck w/o dye	1.20	0.37	0.37	0.08	XXX
70548		A	Mr angiography neck w/dye	1.20	9.41	NA	0.08	XXX
70548	TC	A	Mr angiography neck w/dye	0.00	9.04	NA	0.00	XXX
70548	26	A	Mr angiography neck w/dye	1.20	0.37	0.37	0.08	XXX
70549		A	Mr angiograph neck w/o&w/dye	1.80	13.31	NA	0.13	XXX
70549	TC	A	Mr angiograph neck w/o&w/dye	0.00	12.76	NA	0.01	XXX
70549	26	A	Mr angiograph neck w/o&w/dye	1.80	0.55	0.55	0.12	XXX
70551		A	Mri brain w/o dye	1.48	7.99	NA	0.11	XXX
70551	TC	A	Mri brain w/o dye	0.00	7.53	NA	0.00	XXX
70551	26	A	Mri brain w/o dye	1.48	0.46	0.46	0.10	XXX
70552		A	Mri brain w/dye	1.78	8.86	NA	0.13	XXX
70552	TC	A	Mri brain w/dye	0.00	8.31	NA	0.01	XXX
70552	26	A	Mri brain w/dye	1.78	0.55	0.55	0.13	XXX
70553		A	Mri brain w/o & w/dye	2.36	10.19	NA	0.17	XXX
70553	TC	A	Mri brain w/o & w/dye	0.00	9.47	NA	0.01	XXX
70553	26	A	Mri brain w/o & w/dye	2.36	0.73	0.73	0.16	XXX
70554		A	Fmri brain by tech	2.11	9.41	NA	0.15	XXX
70554	TC	A	Fmri brain by tech	0.00	8.74	NA	0.01	XXX
70554	26	A	Fmri brain by tech	2.11	0.68	0.68	0.15	XXX
70555		C	Fmri brain by phys/psych	0.00	NA	NA	0.00	XXX
70555	TC	C	Fmri brain by phys/psych	0.00	NA	NA	0.00	XXX
70555	26	A	Fmri brain by phys/psych	2.54	0.77	0.77	0.18	XXX
70557		C	Mri brain w/o dye	0.00	NA	NA	0.00	XXX
70557	TC	C	Mri brain w/o dye	0.00	NA	NA	0.00	XXX
70557	26	A	Mri brain w/o dye	2.90	1.36	1.36	0.79	XXX

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CPT[1]/HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
70558		C	Mri brain w/dye	0.00	NA	NA	0.00	XXX
70558	TC	C	Mri brain w/dye	0.00	NA	NA	0.00	XXX
70558	26	A	Mri brain w/dye	3.20	0.97	0.97	0.23	XXX
70559		C	Mri brain w/o & w/dye	0.00	NA	NA	0.00	XXX
70559	TC	C	Mri brain w/o & w/dye	0.00	NA	NA	0.00	XXX
70559	26	A	Mri brain w/o & w/dye	3.20	1.07	1.07	0.23	XXX
71010		A	Chest x-ray	0.18	0.38	NA	0.01	XXX
71010	TC	A	Chest x-ray	0.00	0.33	NA	0.00	XXX
71010	26	A	Chest x-ray	0.18	0.05	0.05	0.01	XXX
71015		A	Chest x-ray	0.21	0.55	NA	0.01	XXX
71015	TC	A	Chest x-ray	0.00	0.48	NA	0.00	XXX
71015	26	A	Chest x-ray	0.21	0.07	0.07	0.01	XXX
71020		A	Chest x-ray	0.22	0.52	NA	0.01	XXX
71020	TC	A	Chest x-ray	0.00	0.46	NA	0.00	XXX
71020	26	A	Chest x-ray	0.22	0.07	0.07	0.01	XXX
71021		A	Chest x-ray	0.27	0.65	NA	0.02	XXX
71021	TC	A	Chest x-ray	0.00	0.57	NA	0.00	XXX
71021	26	A	Chest x-ray	0.27	0.08	0.08	0.01	XXX
71022		A	Chest x-ray	0.31	0.85	NA	0.02	XXX
71022	TC	A	Chest x-ray	0.00	0.75	NA	0.00	XXX
71022	26	A	Chest x-ray	0.31	0.10	0.10	0.02	XXX
71023		A	Chest x-ray and fluoroscopy	0.38	1.39	NA	0.02	XXX
71023	TC	A	Chest x-ray and fluoroscopy	0.00	1.26	NA	0.00	XXX
71023	26	A	Chest x-ray and fluoroscopy	0.38	0.13	0.13	0.02	XXX
71030		A	Chest x-ray	0.31	0.82	NA	0.02	XXX
71030	TC	A	Chest x-ray	0.00	0.73	NA	0.00	XXX
71030	26	A	Chest x-ray	0.31	0.10	0.10	0.02	XXX
71034		A	Chest x-ray and fluoroscopy	0.46	1.66	NA	0.03	XXX
71034	TC	A	Chest x-ray and fluoroscopy	0.00	1.51	NA	0.00	XXX
71034	26	A	Chest x-ray and fluoroscopy	0.46	0.15	0.15	0.02	XXX
71035		A	Chest x-ray	0.18	0.69	NA	0.01	XXX
71035	TC	A	Chest x-ray	0.00	0.64	NA	0.00	XXX
71035	26	A	Chest x-ray	0.18	0.05	0.05	0.01	XXX
71040		A	Contrast x-ray of bronchi	0.58	1.85	NA	0.02	XXX
71040	TC	A	Contrast x-ray of bronchi	0.00	1.67	NA	0.00	XXX
71040	26	A	Contrast x-ray of bronchi	0.58	0.18	0.18	0.02	XXX
71060		A	Contrast x-ray of bronchi	0.74	2.87	NA	0.05	XXX
71060	TC	A	Contrast x-ray of bronchi	0.00	2.63	NA	0.00	XXX
71060	26	A	Contrast x-ray of bronchi	0.74	0.24	0.24	0.05	XXX
71090		C	X-ray & pacemaker insertion	0.00	NA	NA	0.00	XXX
71090	TC	C	X-ray & pacemaker insertion	0.00	NA	NA	0.00	XXX
71090	26	A	X-ray & pacemaker insertion	0.54	0.18	0.18	0.03	XXX
71100		A	X-ray exam of ribs	0.22	0.57	NA	0.02	XXX
71100	TC	A	X-ray exam of ribs	0.00	0.50	NA	0.00	XXX
71100	26	A	X-ray exam of ribs	0.22	0.07	0.07	0.02	XXX
71101		A	X-ray exam of ribs/chest	0.27	0.70	NA	0.02	XXX
71101	TC	A	X-ray exam of ribs/chest	0.00	0.61	NA	0.00	XXX
71101	26	A	X-ray exam of ribs/chest	0.27	0.08	0.08	0.02	XXX
71110		A	X-ray exam of ribs	0.27	0.71	NA	0.02	XXX
71110	TC	A	X-ray exam of ribs	0.00	0.63	NA	0.00	XXX
71110	26	A	X-ray exam of ribs	0.27	0.08	0.08	0.02	XXX
71111		A	X-ray exam of ribs/chest	0.32	0.96	NA	0.02	XXX
71111	TC	A	X-ray exam of ribs/chest	0.00	0.87	NA	0.00	XXX
71111	26	A	X-ray exam of ribs/chest	0.32	0.09	0.09	0.02	XXX
71120		A	X-ray exam of breastbone	0.20	0.57	NA	0.01	XXX
71120	TC	A	X-ray exam of breastbone	0.00	0.51	NA	0.00	XXX
71120	26	A	X-ray exam of breastbone	0.20	0.06	0.06	0.01	XXX
71130		A	X-ray exam of breastbone	0.22	0.70	NA	0.02	XXX
71130	TC	A	X-ray exam of breastbone	0.00	0.63	NA	0.00	XXX
71130	26	A	X-ray exam of breastbone	0.22	0.07	0.07	0.02	XXX
71250		A	Ct thorax w/o dye	1.16	3.76	NA	0.08	XXX
71250	TC	A	Ct thorax w/o dye	0.00	3.40	NA	0.00	XXX
71250	26	A	Ct thorax w/o dye	1.16	0.35	0.35	0.08	XXX
71260		A	Ct thorax w/dye	1.24	4.66	NA	0.09	XXX
71260	TC	A	Ct thorax w/dye	0.00	4.28	NA	0.00	XXX
71260	26	A	Ct thorax w/dye	1.24	0.38	0.38	0.08	XXX
71270		A	Ct thorax w/o & w/dye	1.38	5.80	NA	0.10	XXX
71270	TC	A	Ct thorax w/o & w/dye	0.00	5.37	NA	0.00	XXX
71270	26	A	Ct thorax w/o & w/dye	1.38	0.42	0.42	0.09	XXX
71275		A	Ct angiography, chest	1.92	7.19	NA	0.13	XXX
71275	TC	A	Ct angiography, chest	0.00	6.61	NA	0.01	XXX
71275	26	A	Ct angiography, chest	1.92	0.58	0.58	0.13	XXX
71550		A	Mri chest w/o dye	1.46	8.86	NA	0.11	XXX
71550	TC	A	Mri chest w/o dye	0.00	8.41	NA	0.00	XXX
71550	26	A	Mri chest w/o dye	1.46	0.45	0.45	0.10	XXX
71551		A	Mri chest w/dye	1.73	9.97	NA	0.12	XXX
71551	TC	A	Mri chest w/dye	0.00	9.43	NA	0.00	XXX
71551	26	A	Mri chest w/dye	1.73	0.54	0.54	0.12	XXX
71552		A	Mri chest w/o & w/dye	2.26	12.31	NA	0.16	XXX
71552	TC	A	Mri chest w/o & w/dye	0.00	11.62	NA	0.01	XXX
71552	26	A	Mri chest w/o & w/dye	2.26	0.69	0.69	0.15	XXX
71555		R	Mri angio chest w or w/o dye	1.81	8.69	NA	0.12	XXX
71555	TC	R	Mri angio chest w or w/o dye	0.00	8.13	NA	0.01	XXX
71555	26	R	Mri angio chest w or w/o dye	1.81	0.56	0.56	0.12	XXX

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CPT[1,2] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
72010		A	X-ray exam of spine	0.45	1.50	NA	0.03	XXX
72010	TC	A	X-ray exam of spine	0.00	1.33	NA	0.00	XXX
72010	26	A	X-ray exam of spine	0.45	0.17	0.17	0.03	XXX
72020		A	X-ray exam of spine	0.15	0.43	NA	0.02	XXX
72020	TC	A	X-ray exam of spine	0.00	0.38	NA	0.00	XXX
72020	26	A	X-ray exam of spine	0.15	0.05	0.05	0.01	XXX
72040		A	X-ray exam of neck spine	0.22	0.75	NA	0.02	XXX
72040	TC	A	X-ray exam of neck spine	0.00	0.67	NA	0.00	XXX
72040	26	A	X-ray exam of neck spine	0.22	0.08	0.08	0.02	XXX
72050		A	X-ray exam of neck spine	0.31	0.99	NA	0.03	XXX
72050	TC	A	X-ray exam of neck spine	0.00	0.89	NA	0.00	XXX
72050	26	A	X-ray exam of neck spine	0.31	0.10	0.10	0.03	XXX
72052		A	X-ray exam of neck spine	0.36	1.32	NA	0.03	XXX
72052	TC	A	X-ray exam of neck spine	0.00	1.20	NA	0.00	XXX
72052	26	A	X-ray exam of neck spine	0.36	0.12	0.12	0.03	XXX
72069		A	X-ray exam of trunk spine	0.22	0.72	NA	0.03	XXX
72069	TC	A	X-ray exam of trunk spine	0.00	0.64	NA	0.00	XXX
72069	26	A	X-ray exam of trunk spine	0.22	0.08	0.08	0.03	XXX
72070		A	X-ray exam of thoracic spine	0.22	0.60	NA	0.02	XXX
72070	TC	A	X-ray exam of thoracic spine	0.00	0.53	NA	0.00	XXX
72070	26	A	X-ray exam of thoracic spine	0.22	0.07	0.07	0.02	XXX
72072		A	X-ray exam of thoracic spine	0.22	0.69	NA	0.02	XXX
72072	TC	A	X-ray exam of thoracic spine	0.00	0.63	NA	0.00	XXX
72072	26	A	X-ray exam of thoracic spine	0.22	0.07	0.07	0.01	XXX
72074		A	X-ray exam of thoracic spine	0.22	0.87	NA	0.02	XXX
72074	TC	A	X-ray exam of thoracic spine	0.00	0.80	NA	0.00	XXX
72074	26	A	X-ray exam of thoracic spine	0.22	0.07	0.07	0.02	XXX
72080		A	X-ray exam of trunk spine	0.22	0.69	NA	0.03	XXX
72080	TC	A	X-ray exam of trunk spine	0.00	0.61	NA	0.00	XXX
72080	26	A	X-ray exam of trunk spine	0.22	0.08	0.08	0.03	XXX
72090		A	X-ray exam of trunk spine	0.28	0.98	NA	0.04	XXX
72090	TC	A	X-ray exam of trunk spine	0.00	0.88	NA	0.00	XXX
72090	26	A	X-ray exam of trunk spine	0.28	0.10	0.10	0.03	XXX
72100		A	X-ray exam of lower spine	0.22	0.79	NA	0.03	XXX
72100	TC	A	X-ray exam of lower spine	0.00	0.72	NA	0.00	XXX
72100	26	A	X-ray exam of lower spine	0.22	0.08	0.08	0.02	XXX
72110		A	X-ray exam of lower spine	0.31	1.07	NA	0.03	XXX
72110	TC	A	X-ray exam of lower spine	0.00	0.96	NA	0.00	XXX
72110	26	A	X-ray exam of lower spine	0.31	0.10	0.10	0.03	XXX
72114		A	X-ray exam of lower spine	0.36	1.54	NA	0.04	XXX
72114	TC	A	X-ray exam of lower spine	0.00	1.40	NA	0.00	XXX
72114	26	A	X-ray exam of lower spine	0.36	0.13	0.13	0.04	XXX
72120		A	X-ray exam of lower spine	0.22	1.10	NA	0.03	XXX
72120	TC	A	X-ray exam of lower spine	0.00	1.01	NA	0.00	XXX
72120	26	A	X-ray exam of lower spine	0.22	0.09	0.09	0.03	XXX
72125		A	Ct neck spine w/o dye	1.16	3.79	NA	0.09	XXX
72125	TC	A	Ct neck spine w/o dye	0.00	3.44	NA	0.00	XXX
72125	26	A	Ct neck spine w/o dye	1.16	0.35	0.35	0.08	XXX
72126		A	Ct neck spine w/dye	1.22	4.68	NA	0.09	XXX
72126	TC	A	Ct neck spine w/dye	0.00	4.31	NA	0.00	XXX
72126	26	A	Ct neck spine w/dye	1.22	0.37	0.37	0.09	XXX
72127		A	Ct neck spine w/o & w/dye	1.27	5.78	NA	0.09	XXX
72127	TC	A	Ct neck spine w/o & w/dye	0.00	5.39	NA	0.00	XXX
72127	26	A	Ct neck spine w/o & w/dye	1.27	0.39	0.39	0.09	XXX
72128		A	Ct chest spine w/o dye	1.16	3.78	NA	0.08	XXX
72128	TC	A	Ct chest spine w/o dye	0.00	3.42	NA	0.00	XXX
72128	26	A	Ct chest spine w/o dye	1.16	0.35	0.35	0.08	XXX
72129		A	Ct chest spine w/dye	1.22	4.69	NA	0.09	XXX
72129	TC	A	Ct chest spine w/dye	0.00	4.32	NA	0.00	XXX
72129	26	A	Ct chest spine w/dye	1.22	0.37	0.37	0.09	XXX
72130		A	Ct chest spine w/o & w/dye	1.27	5.83	NA	0.09	XXX
72130	TC	A	Ct chest spine w/o & w/dye	0.00	5.44	NA	0.00	XXX
72130	26	A	Ct chest spine w/o & w/dye	1.27	0.39	0.39	0.08	XXX
72131		A	Ct lumbar spine w/o dye	1.16	3.77	NA	0.08	XXX
72131	TC	A	Ct lumbar spine w/o dye	0.00	3.42	NA	0.00	XXX
72131	26	A	Ct lumbar spine w/o dye	1.16	0.36	0.36	0.08	XXX
72132		A	Ct lumbar spine w/dye	1.22	4.67	NA	0.09	XXX
72132	TC	A	Ct lumbar spine w/dye	0.00	4.30	NA	0.00	XXX
72132	26	A	Ct lumbar spine w/dye	1.22	0.37	0.37	0.09	XXX
72133		A	Ct lumbar spine w/o & w/dye	1.27	5.78	NA	0.09	XXX
72133	TC	A	Ct lumbar spine w/o & w/dye	0.00	5.39	NA	0.00	XXX
72133	26	A	Ct lumbar spine w/o & w/dye	1.27	0.39	0.39	0.09	XXX
72141		A	Mri neck spine w/o dye	1.60	6.92	NA	0.12	XXX
72141	TC	A	Mri neck spine w/o dye	0.00	6.42	NA	0.00	XXX
72141	26	A	Mri neck spine w/o dye	1.60	0.50	0.50	0.12	XXX
72142		A	Mri neck spine w/dye	1.92	8.96	NA	0.14	XXX
72142	TC	A	Mri neck spine w/dye	0.00	8.36	NA	0.01	XXX
72142	26	A	Mri neck spine w/dye	1.92	0.60	0.60	0.14	XXX
72146		A	Mri chest spine w/o dye	1.60	6.94	NA	0.12	XXX
72146	TC	A	Mri chest spine w/o dye	0.00	6.44	NA	0.00	XXX
72146	26	A	Mri chest spine w/o dye	1.60	0.50	0.50	0.12	XXX
72147		A	Mri chest spine w/dye	1.92	7.78	NA	0.14	XXX
72147	TC	A	Mri chest spine w/dye	0.00	7.19	NA	0.01	XXX
72147	26	A	Mri chest spine w/dye	1.92	0.60	0.60	0.13	XXX

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[4] Global totals for malpractice RVUs may not sum due to rounding.

CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
72148		A	Mri lumbar spine w/o dye	1.48	6.90	NA	0.11	XXX
72148	TC	A	Mri lumbar spine w/o dye	0.00	6.43	NA	0.00	XXX
72148	26	A	Mri lumbar spine w/o dye	1.48	0.47	0.47	0.11	XXX
72149		A	Mri lumbar spine w/dye	1.78	8.80	NA	0.14	XXX
72149	TC	A	Mri lumbar spine w/dye	0.00	8.24	NA	0.01	XXX
72149	26	A	Mri lumbar spine w/dye	1.78	0.56	0.56	0.13	XXX
72156		A	Mri neck spine w/o & w/dye	2.57	10.08	NA	0.19	XXX
72156	TC	A	Mri neck spine w/o & w/dye	0.00	9.28	NA	0.01	XXX
72156	26	A	Mri neck spine w/o & w/dye	2.57	0.80	0.80	0.19	XXX
72157		A	Mri chest spine w/o & w/dye	2.57	9.21	NA	0.19	XXX
72157	TC	A	Mri chest spine w/o & w/dye	0.00	8.42	NA	0.01	XXX
72157	26	A	Mri chest spine w/o & w/dye	2.57	0.79	0.79	0.18	XXX
72158		A	Mri lumbar spine w/o & w/dye	2.36	9.96	NA	0.18	XXX
72158	TC	A	Mri lumbar spine w/o & w/dye	0.00	9.22	NA	0.01	XXX
72158	26	A	Mri lumbar spine w/o & w/dye	2.36	0.74	0.74	0.18	XXX
72159		N	Mr angio spine w/o&w/dye	1.80	10.37	NA	0.10	XXX
72159	TC	N	Mr angio spine w/o&w/dye	0.00	9.71	NA	0.01	XXX
72159	26	N	Mr angio spine w/o&w/dye	1.80	0.66	0.66	0.09	XXX
72170		A	X-ray exam of pelvis	0.17	0.48	NA	0.02	XXX
72170	TC	A	X-ray exam of pelvis	0.00	0.42	NA	0.00	XXX
72170	26	A	X-ray exam of pelvis	0.17	0.06	0.06	0.02	XXX
72190		A	X-ray exam of pelvis	0.21	0.83	NA	0.03	XXX
72190	TC	A	X-ray exam of pelvis	0.00	0.75	NA	0.00	XXX
72190	26	A	X-ray exam of pelvis	0.21	0.08	0.08	0.03	XXX
72191		A	Ct angiograph pelv w/o&w/dye	1.81	6.81	NA	0.15	XXX
72191	TC	A	Ct angiograph pelv w/o&w/dye	0.00	6.27	NA	0.01	XXX
72191	26	A	Ct angiograph pelv w/o&w/dye	1.81	0.55	0.55	0.14	XXX
72192		A	Ct pelvis w/o dye	1.09	3.50	NA	0.08	XXX
72192	TC	A	Ct pelvis w/o dye	0.00	3.17	NA	0.00	XXX
72192	26	A	Ct pelvis w/o dye	1.09	0.33	0.33	0.07	XXX
72193		A	Ct pelvis w/dye	1.16	4.39	NA	0.08	XXX
72193	TC	A	Ct pelvis w/dye	0.00	4.03	NA	0.00	XXX
72193	26	A	Ct pelvis w/dye	1.16	0.36	0.36	0.08	XXX
72194		A	Ct pelvis w/o & w/dye	1.22	5.82	NA	0.09	XXX
72194	TC	A	Ct pelvis w/o & w/dye	0.00	5.45	NA	0.00	XXX
72194	26	A	Ct pelvis w/o & w/dye	1.22	0.37	0.37	0.08	XXX
72195		A	Mri pelvis w/o dye	1.46	7.93	NA	0.11	XXX
72195	TC	A	Mri pelvis w/o dye	0.00	7.47	NA	0.00	XXX
72195	26	A	Mri pelvis w/o dye	1.46	0.46	0.46	0.11	XXX
72196		A	Mri pelvis w/dye	1.73	8.75	NA	0.13	XXX
72196	TC	A	Mri pelvis w/dye	0.00	8.22	NA	0.00	XXX
72196	26	A	Mri pelvis w/dye	1.73	0.54	0.54	0.12	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
72197		A	Mri pelvis w/o & w/dye	2.26	10.51	NA	0.16	XXX
72197	TC	A	Mri pelvis w/o & w/dye	0.00	9.82	NA	0.01	XXX
72197	26	A	Mri pelvis w/o & w/dye	2.26	0.69	0.69	0.16	XXX
72198		A	Mr angio pelvis w/o & w/dye	1.80	8.69	NA	0.13	XXX
72198	TC	A	Mr angio pelvis w/o & w/dye	0.00	8.14	NA	0.01	XXX
72198	26	A	Mr angio pelvis w/o & w/dye	1.80	0.55	0.55	0.12	XXX
72200		A	X-ray exam sacroiliac joints	0.17	0.56	NA	0.01	XXX
72200	TC	A	X-ray exam sacroiliac joints	0.00	0.50	NA	0.00	XXX
72200	26	A	X-ray exam sacroiliac joints	0.17	0.06	0.06	0.01	XXX
72202		A	X-ray exam sacroiliac joints	0.19	0.66	NA	0.01	XXX
72202	TC	A	X-ray exam sacroiliac joints	0.00	0.60	NA	0.00	XXX
72202	26	A	X-ray exam sacroiliac joints	0.19	0.06	0.06	0.01	XXX
72220		A	X-ray exam of tailbone	0.17	0.52	NA	0.01	XXX
72220	TC	A	X-ray exam of tailbone	0.00	0.47	NA	0.00	XXX
72220	26	A	X-ray exam of tailbone	0.17	0.05	0.05	0.01	XXX
72240		A	Contrast x-ray of neck spine	0.91	2.35	NA	0.07	XXX
72240	TC	A	Contrast x-ray of neck spine	0.00	2.07	NA	0.00	XXX
72240	26	A	Contrast x-ray of neck spine	0.91	0.28	0.28	0.06	XXX
72255		A	Contrast x-ray, thorax spine	0.91	2.29	NA	0.06	XXX
72255	TC	A	Contrast x-ray, thorax spine	0.00	1.98	NA	0.00	XXX
72255	26	A	Contrast x-ray, thorax spine	0.91	0.31	0.31	0.06	XXX
72265		A	Contrast x-ray, lower spine	0.83	2.36	NA	0.06	XXX
72265	TC	A	Contrast x-ray, lower spine	0.00	2.09	NA	0.00	XXX
72265	26	A	Contrast x-ray, lower spine	0.83	0.27	0.27	0.06	XXX
72270		A	Contrast x-ray, spine	1.33	3.63	NA	0.09	XXX
72270	TC	A	Contrast x-ray, spine	0.00	3.21	NA	0.00	XXX
72270	26	A	Contrast x-ray, spine	1.33	0.42	0.42	0.08	XXX
72275		A	Epidurography	0.76	2.24	NA	0.05	XXX
72275	TC	A	Epidurography	0.00	1.94	NA	0.00	XXX
72275	26	A	Epidurography	0.76	0.31	0.31	0.05	XXX
72285		A	X-ray c/t spine disk	1.16	1.92	NA	0.08	XXX
72285	TC	A	X-ray c/t spine disk	0.00	1.43	NA	0.00	XXX
72285	26	A	X-ray c/t spine disk	1.16	0.49	0.49	0.08	XXX
72291		C	Perq vertebroplasty, fluor	0.00	NA	NA	0.00	XXX
72291	TC	C	Perq vertebroplasty, fluor	0.00	NA	NA	0.00	XXX
72291	26	A	Perq vertebroplasty, fluor	1.31	0.49	0.49	0.16	XXX
72292		C	Perq vertebroplasty, ct	0.00	NA	NA	0.00	XXX
72292	TC	C	Perq vertebroplasty, ct	0.00	NA	NA	0.00	XXX
72292	26	A	Perq vertebroplasty, ct	1.38	0.49	0.49	0.15	XXX
72295		A	X-ray of lower spine disk	0.83	1.79	NA	0.05	XXX
72295	TC	A	X-ray of lower spine disk	0.00	1.45	NA	0.00	XXX
72295	26	A	X-ray of lower spine disk	0.83	0.34	0.34	0.05	XXX

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CPT[1,2]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
73000		A	X-ray exam of collar bone	0.16	0.55	NA	0.02	XXX
73000	TC	A	X-ray exam of collar bone	0.00	0.50	NA	0.00	XXX
73000	26	A	X-ray exam of collar bone	0.16	0.06	0.06	0.02	XXX
73010		A	X-ray exam of shoulder blade	0.17	0.60	NA	0.02	XXX
73010	TC	A	X-ray exam of shoulder blade	0.00	0.53	NA	0.00	XXX
73010	26	A	X-ray exam of shoulder blade	0.17	0.07	0.07	0.02	XXX
73020		A	X-ray exam of shoulder	0.15	0.44	NA	0.02	XXX
73020	TC	A	X-ray exam of shoulder	0.00	0.38	NA	0.00	XXX
73020	26	A	X-ray exam of shoulder	0.15	0.05	0.05	0.02	XXX
73030		A	X-ray exam of shoulder	0.18	0.57	NA	0.02	XXX
73030	TC	A	X-ray exam of shoulder	0.00	0.50	NA	0.00	XXX
73030	26	A	X-ray exam of shoulder	0.18	0.07	0.07	0.02	XXX
73040		A	Contrast x-ray of shoulder	0.54	2.13	NA	0.05	XXX
73040	TC	A	Contrast x-ray of shoulder	0.00	1.94	NA	0.00	XXX
73040	26	A	Contrast x-ray of shoulder	0.54	0.18	0.18	0.05	XXX
73050		A	X-ray exam of shoulders	0.20	0.78	NA	0.03	XXX
73050	TC	A	X-ray exam of shoulders	0.00	0.70	NA	0.00	XXX
73050	26	A	X-ray exam of shoulders	0.20	0.08	0.08	0.03	XXX
73060		A	X-ray exam of humerus	0.17	0.54	NA	0.02	XXX
73060	TC	A	X-ray exam of humerus	0.00	0.48	NA	0.00	XXX
73060	26	A	X-ray exam of humerus	0.17	0.05	0.05	0.02	XXX
73070		A	X-ray exam of elbow	0.15	0.55	NA	0.02	XXX
73070	TC	A	X-ray exam of elbow	0.00	0.50	NA	0.00	XXX
73070	26	A	X-ray exam of elbow	0.15	0.05	0.05	0.02	XXX
73080		A	X-ray exam of elbow	0.17	0.72	NA	0.02	XXX
73080	TC	A	X-ray exam of elbow	0.00	0.66	NA	0.00	XXX
73080	26	A	X-ray exam of elbow	0.17	0.06	0.06	0.02	XXX
73085		A	Contrast x-ray of elbow	0.54	1.87	NA	0.04	XXX
73085	TC	A	Contrast x-ray of elbow	0.00	1.68	NA	0.00	XXX
73085	26	A	Contrast x-ray of elbow	0.54	0.20	0.20	0.04	XXX
73090		A	X-ray exam of forearm	0.16	0.51	NA	0.02	XXX
73090	TC	A	X-ray exam of forearm	0.00	0.46	NA	0.00	XXX
73090	26	A	X-ray exam of forearm	0.16	0.05	0.05	0.02	XXX
73092		A	X-ray exam of arm, infant	0.16	0.59	NA	0.01	XXX
73092	TC	A	X-ray exam of arm, infant	0.00	0.54	NA	0.00	XXX
73092	26	A	X-ray exam of arm, infant	0.16	0.05	0.05	0.01	XXX
73100		A	X-ray exam of wrist	0.16	0.63	NA	0.02	XXX
73100	TC	A	X-ray exam of wrist	0.00	0.56	NA	0.00	XXX
73100	26	A	X-ray exam of wrist	0.16	0.07	0.07	0.02	XXX
73110		A	X-ray exam of wrist	0.17	0.76	NA	0.02	XXX
73110	TC	A	X-ray exam of wrist	0.00	0.70	NA	0.00	XXX
73110	26	A	X-ray exam of wrist	0.17	0.06	0.06	0.02	XXX
73115		A	Contrast x-ray of wrist	0.54	2.26	NA	0.04	XXX
73115	TC	A	Contrast x-ray of wrist	0.00	2.06	NA	0.00	XXX
73115	26	A	Contrast x-ray of wrist	0.54	0.20	0.20	0.04	XXX
73120		A	X-ray exam of hand	0.16	0.52	NA	0.01	XXX
73120	TC	A	X-ray exam of hand	0.00	0.46	NA	0.00	XXX
73120	26	A	X-ray exam of hand	0.16	0.06	0.06	0.01	XXX
73130		A	X-ray exam of hand	0.17	0.62	NA	0.02	XXX
73130	TC	A	X-ray exam of hand	0.00	0.57	NA	0.00	XXX
73130	26	A	X-ray exam of hand	0.17	0.06	0.06	0.02	XXX
73140		A	X-ray exam of finger(s)	0.13	0.70	NA	0.02	XXX
73140	TC	A	X-ray exam of finger(s)	0.00	0.65	NA	0.00	XXX
73140	26	A	X-ray exam of finger(s)	0.13	0.05	0.05	0.02	XXX
73200		A	Ct upper extremity w/o dye	1.09	3.73	NA	0.08	XXX
73200	TC	A	Ct upper extremity w/o dye	0.00	3.40	NA	0.00	XXX
73200	26	A	Ct upper extremity w/o dye	1.09	0.34	0.34	0.08	XXX
73201		A	Ct upper extremity w/dye	1.16	4.61	NA	0.08	XXX
73201	TC	A	Ct upper extremity w/dye	0.00	4.26	NA	0.00	XXX
73201	26	A	Ct upper extremity w/dye	1.16	0.35	0.35	0.08	XXX
73202		A	Ct upper extremity w/o&w/dye	1.22	6.10	NA	0.09	XXX
73202	TC	A	Ct upper extremity w/o&w/dye	0.00	5.72	NA	0.00	XXX
73202	26	A	Ct upper extremity w/o&w/dye	1.22	0.37	0.37	0.08	XXX
73206		A	Ct angio upr extrm w/o&w/dye	1.81	6.47	NA	0.12	XXX
73206	TC	A	Ct angio upr extrm w/o&w/dye	0.00	5.91	NA	0.01	XXX
73206	26	A	Ct angio upr extrm w/o&w/dye	1.81	0.55	0.55	0.11	XXX
73218		A	Mri upper extremity w/o dye	1.35	7.92	NA	0.09	XXX
73218	TC	A	Mri upper extremity w/o dye	0.00	7.49	NA	0.00	XXX
73218	26	A	Mri upper extremity w/o dye	1.35	0.43	0.43	0.09	XXX
73219		A	Mri upper extremity w/dye	1.62	8.72	NA	0.12	XXX
73219	TC	A	Mri upper extremity w/dye	0.00	8.21	NA	0.00	XXX
73219	26	A	Mri upper extremity w/dye	1.62	0.51	0.51	0.12	XXX
73220		A	Mri upper extremity w/o&w/dye	2.15	10.61	NA	0.16	XXX
73220	TC	A	Mri upper extremity w/o&w/dye	0.00	9.94	NA	0.01	XXX
73220	26	A	Mri upper extremity w/o&w/dye	2.15	0.67	0.67	0.15	XXX
73221		A	Mri joint upr extrem w/o dye	1.35	7.51	NA	0.11	XXX
73221	TC	A	Mri joint upr extrem w/o dye	0.00	7.06	NA	0.00	XXX
73221	26	A	Mri joint upr extrem w/o dye	1.35	0.44	0.44	0.11	XXX
73222		A	Mri joint upr extrem w/dye	1.62	8.06	NA	0.12	XXX
73222	TC	A	Mri joint upr extrem w/dye	0.00	7.55	NA	0.00	XXX
73222	26	A	Mri joint upr extrem w/dye	1.62	0.51	0.51	0.12	XXX
73223		A	Mri joint upr extr w/o&w/dye	2.15	9.90	NA	0.16	XXX
73223	TC	A	Mri joint upr extr w/o&w/dye	0.00	9.23	NA	0.01	XXX
73223	26	A	Mri joint upr extr w/o&w/dye	2.15	0.67	0.67	0.16	XXX

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[4] Global totals for malpractice RVUs may not sum due to rounding.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
73225		N	Mr angio upr extr w/o&w/dye	1.73	10.34	NA	0.09	XXX
73225	TC	N	Mr angio upr extr w/o&w/dye	0.00	9.71	NA	0.00	XXX
73225	26	N	Mr angio upr extr w/o&w/dye	1.73	0.63	0.63	0.09	XXX
73500		A	X-ray exam of hip	0.17	0.49	NA	0.02	XXX
73500	TC	A	X-ray exam of hip	0.00	0.42	NA	0.00	XXX
73500	26	A	X-ray exam of hip	0.17	0.06	0.06	0.02	XXX
73510		A	X-ray exam of hip	0.21	0.74	NA	0.03	XXX
73510	TC	A	X-ray exam of hip	0.00	0.67	NA	0.00	XXX
73510	26	A	X-ray exam of hip	0.21	0.07	0.07	0.03	XXX
73520		A	X-ray exam of hips	0.26	0.75	NA	0.03	XXX
73520	TC	A	X-ray exam of hips	0.00	0.66	NA	0.00	XXX
73520	26	A	X-ray exam of hips	0.26	0.09	0.09	0.03	XXX
73525		A	Contrast x-ray of hip	0.54	2.01	NA	0.04	XXX
73525	TC	A	Contrast x-ray of hip	0.00	1.80	NA	0.00	XXX
73525	26	A	Contrast x-ray of hip	0.54	0.21	0.21	0.04	XXX
73530		C	X-ray exam of hip	0.00	NA	NA	0.00	XXX
73530	TC	C	X-ray exam of hip	0.00	NA	NA	0.00	XXX
73530	26	A	X-ray exam of hip	0.29	0.09	0.09	0.02	XXX
73540		A	X-ray exam of pelvis & hips	0.20	0.90	NA	0.03	XXX
73540	TC	A	X-ray exam of pelvis & hips	0.00	0.82	NA	0.00	XXX
73540	26	A	X-ray exam of pelvis & hips	0.20	0.09	0.09	0.03	XXX
73542		A	X-ray exam, sacroiliac joint	0.59	1.60	NA	0.03	XXX
73542	TC	A	X-ray exam, sacroiliac joint	0.00	1.35	NA	0.00	XXX
73542	26	A	X-ray exam, sacroiliac joint	0.59	0.25	0.25	0.03	XXX
73550		A	X-ray exam of thigh	0.17	0.51	NA	0.02	XXX
73550	TC	A	X-ray exam of thigh	0.00	0.45	NA	0.00	XXX
73550	26	A	X-ray exam of thigh	0.17	0.05	0.05	0.02	XXX
73560		A	X-ray exam of knee, 1 or 2	0.17	0.59	NA	0.02	XXX
73560	TC	A	X-ray exam of knee, 1 or 2	0.00	0.52	NA	0.00	XXX
73560	26	A	X-ray exam of knee, 1 or 2	0.17	0.06	0.06	0.02	XXX
73562		A	X-ray exam of knee, 3	0.18	0.75	NA	0.02	XXX
73562	TC	A	X-ray exam of knee, 3	0.00	0.68	NA	0.00	XXX
73562	26	A	X-ray exam of knee, 3	0.18	0.07	0.07	0.02	XXX
73564		A	X-ray exam, knee, 4 or more	0.22	0.86	NA	0.03	XXX
73564	TC	A	X-ray exam, knee, 4 or more	0.00	0.78	NA	0.00	XXX
73564	26	A	X-ray exam, knee, 4 or more	0.22	0.09	0.09	0.03	XXX
73565		A	X-ray exam of knees	0.17	0.71	NA	0.02	XXX
73565	TC	A	X-ray exam of knees	0.00	0.64	NA	0.00	XXX
73565	26	A	X-ray exam of knees	0.17	0.08	0.08	0.02	XXX
73580		A	Contrast x-ray of knee joint	0.54	2.93	NA	0.06	XXX
73580	TC	A	Contrast x-ray of knee joint	0.00	2.68	NA	0.00	XXX
73580	26	A	Contrast x-ray of knee joint	0.54	0.25	0.25	0.06	XXX
73590		A	X-ray exam of lower leg	0.17	0.50	NA	0.02	XXX
73590	TC	A	X-ray exam of lower leg	0.00	0.45	NA	0.00	XXX
73590	26	A	X-ray exam of lower leg	0.17	0.05	0.05	0.02	XXX
73592		A	X-ray exam of leg, infant	0.16	0.62	NA	0.02	XXX
73592	TC	A	X-ray exam of leg, infant	0.00	0.57	NA	0.00	XXX
73592	26	A	X-ray exam of leg, infant	0.16	0.06	0.06	0.02	XXX
73600		A	X-ray exam of ankle	0.16	0.56	NA	0.02	XXX
73600	TC	A	X-ray exam of ankle	0.00	0.50	NA	0.00	XXX
73600	26	A	X-ray exam of ankle	0.16	0.06	0.06	0.02	XXX
73610		A	X-ray exam of ankle	0.17	0.65	NA	0.02	XXX
73610	TC	A	X-ray exam of ankle	0.00	0.60	NA	0.00	XXX
73610	26	A	X-ray exam of ankle	0.17	0.06	0.06	0.02	XXX
73615		A	Contrast x-ray of ankle	0.54	2.17	NA	0.05	XXX
73615	TC	A	Contrast x-ray of ankle	0.00	1.95	NA	0.00	XXX
73615	26	A	Contrast x-ray of ankle	0.54	0.22	0.22	0.05	XXX
73620		A	X-ray exam of foot	0.16	0.53	NA	0.01	XXX
73620	TC	A	X-ray exam of foot	0.00	0.49	NA	0.00	XXX
73620	26	A	X-ray exam of foot	0.16	0.04	0.04	0.01	XXX
73630		A	X-ray exam of foot	0.17	0.64	NA	0.01	XXX
73630	TC	A	X-ray exam of foot	0.00	0.59	NA	0.00	XXX
73630	26	A	X-ray exam of foot	0.17	0.05	0.05	0.01	XXX
73650		A	X-ray exam of heel	0.16	0.55	NA	0.02	XXX
73650	TC	A	X-ray exam of heel	0.00	0.50	NA	0.00	XXX
73650	26	A	X-ray exam of heel	0.16	0.05	0.05	0.02	XXX
73660		A	X-ray exam of toe(s)	0.13	0.62	NA	0.01	XXX
73660	TC	A	X-ray exam of toe(s)	0.00	0.57	NA	0.00	XXX
73660	26	A	X-ray exam of toe(s)	0.13	0.04	0.04	0.01	XXX
73700		A	Ct lower extremity w/o dye	1.09	3.74	NA	0.08	XXX
73700	TC	A	Ct lower extremity w/o dye	0.00	3.41	NA	0.00	XXX
73700	26	A	Ct lower extremity w/o dye	1.09	0.33	0.33	0.08	XXX
73701		A	Ct lower extremity w/dye	1.16	4.67	NA	0.08	XXX
73701	TC	A	Ct lower extremity w/dye	0.00	4.32	NA	0.00	XXX
73701	26	A	Ct lower extremity w/dye	1.16	0.35	0.35	0.08	XXX
73702		A	Ct lwr extremity w/o&w/dye	1.22	6.13	NA	0.08	XXX
73702	TC	A	Ct lwr extremity w/o&w/dye	0.00	5.76	NA	0.00	XXX
73702	26	A	Ct lwr extremity w/o&w/dye	1.22	0.37	0.37	0.08	XXX
73706		A	Ct angio lwr extr w/o&w/dye	1.90	7.36	NA	0.13	XXX
73706	TC	A	Ct angio lwr extr w/o&w/dye	0.00	6.78	NA	0.01	XXX
73706	26	A	Ct angio lwr extr w/o&w/dye	1.90	0.59	0.59	0.13	XXX
73718		A	Mri lower extremity w/o dye	1.35	7.81	NA	0.10	XXX
73718	TC	A	Mri lower extremity w/o dye	0.00	7.38	NA	0.00	XXX
73718	26	A	Mri lower extremity w/o dye	1.35	0.42	0.42	0.10	XXX

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CPT[1,2] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
73719		A	Mri lower extremity w/dye	1.62	8.62	NA	0.12	XXX
73719	TC	A	Mri lower extremity w/dye	0.00	8.12	NA	0.00	XXX
73719	26	A	Mri lower extremity w/dye	1.62	0.50	0.50	0.11	XXX
73720		A	Mri lwr extremity w/o&w/dye	2.15	10.62	NA	0.15	XXX
73720	TC	A	Mri lwr extremity w/o&w/dye	0.00	9.96	NA	0.01	XXX
73720	26	A	Mri lwr extremity w/o&w/dye	2.15	0.66	0.66	0.15	XXX
73721		A	Mri jnt of lwr extre w/o dye	1.35	7.70	NA	0.11	XXX
73721	TC	A	Mri jnt of lwr extre w/o dye	0.00	7.26	NA	0.00	XXX
73721	26	A	Mri jnt of lwr extre w/o dye	1.35	0.44	0.44	0.11	XXX
73722		A	Mri joint of lwr extr w/dye	1.62	8.25	NA	0.13	XXX
73722	TC	A	Mri joint of lwr extr w/dye	0.00	7.73	NA	0.00	XXX
73722	26	A	Mri joint of lwr extr w/dye	1.62	0.52	0.52	0.13	XXX
73723		A	Mri joint lwr extr w/o&w/dye	2.15	9.88	NA	0.16	XXX
73723	TC	A	Mri joint lwr extr w/o&w/dye	0.00	9.22	NA	0.01	XXX
73723	26	A	Mri joint lwr extr w/o&w/dye	2.15	0.66	0.66	0.15	XXX
73725		R	Mr ang lwr ext w or w/o dye	1.82	8.71	NA	0.13	XXX
73725	TC	R	Mr ang lwr ext w or w/o dye	0.00	8.16	NA	0.01	XXX
73725	26	R	Mr ang lwr ext w or w/o dye	1.82	0.55	0.55	0.12	XXX
74000		A	X-ray exam of abdomen	0.18	0.41	NA	0.01	XXX
74000	TC	A	X-ray exam of abdomen	0.00	0.36	NA	0.00	XXX
74000	26	A	X-ray exam of abdomen	0.18	0.05	0.05	0.01	XXX
74010		A	X-ray exam of abdomen	0.23	0.71	NA	0.01	XXX
74010	TC	A	X-ray exam of abdomen	0.00	0.64	NA	0.00	XXX
74010	26	A	X-ray exam of abdomen	0.23	0.07	0.07	0.01	XXX
74020		A	X-ray exam of abdomen	0.27	0.72	NA	0.02	XXX
74020	TC	A	X-ray exam of abdomen	0.00	0.64	NA	0.00	XXX
74020	26	A	X-ray exam of abdomen	0.27	0.08	0.08	0.02	XXX
74022		A	X-ray exam series, abdomen	0.32	0.87	NA	0.02	XXX
74022	TC	A	X-ray exam series, abdomen	0.00	0.78	NA	0.00	XXX
74022	26	A	X-ray exam series, abdomen	0.32	0.10	0.10	0.02	XXX
74150		A	Ct abdomen w/o dye	1.19	3.53	NA	0.08	XXX
74150	TC	A	Ct abdomen w/o dye	0.00	3.17	NA	0.00	XXX
74150	26	A	Ct abdomen w/o dye	1.19	0.36	0.36	0.08	XXX
74160		A	Ct abdomen w/dye	1.27	5.12	NA	0.09	XXX
74160	TC	A	Ct abdomen w/dye	0.00	4.73	NA	0.00	XXX
74160	26	A	Ct abdomen w/dye	1.27	0.39	0.39	0.09	XXX
74170		A	Ct abdomen w/o & w/dye	1.40	7.02	NA	0.10	XXX
74170	TC	A	Ct abdomen w/o & w/dye	0.00	6.59	NA	0.00	XXX
74170	26	A	Ct abdomen w/o & w/dye	1.40	0.43	0.43	0.09	XXX
74175		A	Ct angio abdom w/o & w/dye	1.90	7.27	NA	0.15	XXX
74175	TC	A	Ct angio abdom w/o & w/dye	0.00	6.70	NA	0.01	XXX
74175	26	A	Ct angio abdom w/o & w/dye	1.90	0.58	0.58	0.14	XXX
CPT[1,2] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
74181		A	Mri abdomen w/o dye	1.46	6.88	NA	0.10	XXX
74181	TC	A	Mri abdomen w/o dye	0.00	6.43	NA	0.00	XXX
74181	26	A	Mri abdomen w/o dye	1.46	0.44	0.44	0.10	XXX
74182		A	Mri abdomen w/dye	1.73	9.72	NA	0.12	XXX
74182	TC	A	Mri abdomen w/dye	0.00	9.19	NA	0.00	XXX
74182	26	A	Mri abdomen w/dye	1.73	0.52	0.52	0.12	XXX
74183		A	Mri abdomen w/o & w/dye	2.26	10.56	NA	0.16	XXX
74183	TC	A	Mri abdomen w/o & w/dye	0.00	9.87	NA	0.01	XXX
74183	26	A	Mri abdomen w/o & w/dye	2.26	0.69	0.69	0.16	XXX
74185		R	Mri angio, abdom w orw/o dye	1.80	8.64	NA	0.13	XXX
74185	TC	R	Mri angio, abdom w orw/o dye	0.00	8.10	NA	0.01	XXX
74185	26	R	Mri angio, abdom w orw/o dye	1.80	0.55	0.55	0.12	XXX
74190		C	X-ray exam of peritoneum	0.00	NA	NA	0.00	XXX
74190	TC	C	X-ray exam of peritoneum	0.00	NA	NA	0.00	XXX
74190	26	A	X-ray exam of peritoneum	0.48	0.15	0.15	0.04	XXX
74210		A	Contrst x-ray exam of throat	0.36	1.58	NA	0.03	XXX
74210	TC	A	Contrst x-ray exam of throat	0.00	1.47	NA	0.00	XXX
74210	26	A	Contrst x-ray exam of throat	0.36	0.11	0.11	0.02	XXX
74220		A	Contrast x-ray, esophagus	0.46	1.82	NA	0.03	XXX
74220	TC	A	Contrast x-ray, esophagus	0.00	1.68	NA	0.00	XXX
74220	26	A	Contrast x-ray, esophagus	0.46	0.14	0.14	0.03	XXX
74230		A	Cine/vid x-ray, throat/esoph	0.53	1.75	NA	0.04	XXX
74230	TC	A	Cine/vid x-ray, throat/esoph	0.00	1.59	NA	0.00	XXX
74230	26	A	Cine/vid x-ray, throat/esoph	0.53	0.16	0.16	0.04	XXX
74235		C	Remove esophagus obstruction	0.00	NA	NA	0.00	XXX
74235	TC	C	Remove esophagus obstruction	0.00	NA	NA	0.00	XXX
74235	26	A	Remove esophagus obstruction	1.19	0.36	0.36	0.09	XXX
74240		A	X-ray exam, upper gi tract	0.69	2.08	NA	0.05	XXX
74240	TC	A	X-ray exam, upper gi tract	0.00	1.87	NA	0.00	XXX
74240	26	A	X-ray exam, upper gi tract	0.69	0.21	0.21	0.05	XXX
74241		A	X-ray exam, upper gi tract	0.69	2.31	NA	0.04	XXX
74241	TC	A	X-ray exam, upper gi tract	0.00	2.10	NA	0.00	XXX
74241	26	A	X-ray exam, upper gi tract	0.69	0.21	0.21	0.04	XXX
74245		A	X-ray exam, upper gi tract	0.91	3.53	NA	0.06	XXX
74245	TC	A	X-ray exam, upper gi tract	0.00	3.25	NA	0.00	XXX
74245	26	A	X-ray exam, upper gi tract	0.91	0.28	0.28	0.06	XXX
74246		A	Contrst x-ray upper gi tract	0.69	2.49	NA	0.05	XXX
74246	TC	A	Contrst x-ray upper gi tract	0.00	2.28	NA	0.00	XXX
74246	26	A	Contrst x-ray upper gi tract	0.69	0.21	0.21	0.05	XXX
74247		A	Contrst x-ray upper gi tract	0.69	2.87	NA	0.05	XXX
74247	TC	A	Contrst x-ray upper gi tract	0.00	2.66	NA	0.00	XXX
74247	26	A	Contrst x-ray upper gi tract	0.69	0.21	0.21	0.05	XXX

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CPT[1,3] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
74249		A	Contrst x-ray uppr gi tract	0.91	3.89	NA	0.06	XXX
74249	TC	A	Contrst x-ray uppr gi tract	0.00	3.61	NA	0.00	XXX
74249	26	A	Contrst x-ray uppr gi tract	0.91	0.28	0.28	0.06	XXX
74250		A	X-ray exam of small bowel	0.47	2.22	NA	0.03	XXX
74250	TC	A	X-ray exam of small bowel	0.00	2.08	NA	0.00	XXX
74250	26	A	X-ray exam of small bowel	0.47	0.14	0.14	0.03	XXX
74251		A	X-ray exam of small bowel	0.69	9.02	NA	0.05	XXX
74251	TC	A	X-ray exam of small bowel	0.00	8.82	NA	0.00	XXX
74251	26	A	X-ray exam of small bowel	0.69	0.21	0.21	0.05	XXX
74260		A	X-ray exam of small bowel	0.50	7.53	NA	0.04	XXX
74260	TC	A	X-ray exam of small bowel	0.00	7.38	NA	0.00	XXX
74260	26	A	X-ray exam of small bowel	0.50	0.15	0.15	0.03	XXX
74270		A	Contrast x-ray exam of colon	0.69	3.20	NA	0.05	XXX
74270	TC	A	Contrast x-ray exam of colon	0.00	2.99	NA	0.00	XXX
74270	26	A	Contrast x-ray exam of colon	0.69	0.21	0.21	0.05	XXX
74280		A	Contrast x-ray exam of colon	0.99	4.43	NA	0.07	XXX
74280	TC	A	Contrast x-ray exam of colon	0.00	4.13	NA	0.00	XXX
74280	26	A	Contrast x-ray exam of colon	0.99	0.30	0.30	0.07	XXX
74283		A	Contrast x-ray exam of colon	2.02	3.19	NA	0.09	XXX
74283	TC	A	Contrast x-ray exam of colon	0.00	2.56	NA	0.01	XXX
74283	26	A	Contrast x-ray exam of colon	2.02	0.63	0.63	0.09	XXX
74290		A	Contrast x-ray, gallbladder	0.32	1.44	NA	0.02	XXX
74290	TC	A	Contrast x-ray, gallbladder	0.00	1.34	NA	0.00	XXX
74290	26	A	Contrast x-ray, gallbladder	0.32	0.10	0.10	0.02	XXX
74291		A	Contrast x-rays, gallbladder	0.20	1.50	NA	0.01	XXX
74291	TC	A	Contrast x-rays, gallbladder	0.00	1.44	NA	0.00	XXX
74291	26	A	Contrast x-rays, gallbladder	0.20	0.07	0.07	0.01	XXX
74300		C	X-ray bile ducts/pancreas	0.00	NA	NA	0.00	XXX
74300	TC	C	X-ray bile ducts/pancreas	0.00	NA	NA	0.00	XXX
74300	26	A	X-ray bile ducts/pancreas	0.36	0.11	0.11	0.03	XXX
74301		C	X-rays at surgery add-on	0.00	NA	0.00	0.00	ZZZ
74301	TC	C	X-rays at surgery add-on	0.00	NA	0.00	0.00	ZZZ
74301	26	A	X-rays at surgery add-on	0.21	0.07	0.07	0.02	ZZZ
74305		C	X-ray bile ducts/pancreas	0.00	NA	NA	0.00	XXX
74305	TC	C	X-ray bile ducts/pancreas	0.00	NA	NA	0.00	XXX
74305	26	A	X-ray bile ducts/pancreas	0.42	0.13	0.13	0.03	XXX
74320		A	Contrast x-ray of bile ducts	0.54	1.34	NA	0.04	XXX
74320	TC	A	Contrast x-ray of bile ducts	0.00	1.18	NA	0.00	XXX
74320	26	A	Contrast x-ray of bile ducts	0.54	0.16	0.16	0.04	XXX
74327		A	X-ray bile stone removal	0.70	2.08	NA	0.11	XXX
74327	TC	A	X-ray bile stone removal	0.00	1.87	NA	0.00	XXX
74327	26	A	X-ray bile stone removal	0.70	0.21	0.21	0.11	XXX
74328		C	X-ray bile duct endoscopy	0.00	NA	NA	0.00	XXX
74328	TC	C	X-ray bile duct endoscopy	0.00	NA	NA	0.00	XXX
74328	26	A	X-ray bile duct endoscopy	0.70	0.23	0.23	0.05	XXX
74329		C	X-ray for pancreas endoscopy	0.00	NA	NA	0.00	XXX
74329	TC	C	X-ray for pancreas endoscopy	0.00	NA	NA	0.00	XXX
74329	26	A	X-ray for pancreas endoscopy	0.70	0.23	0.23	0.05	XXX
74330		C	X-ray bile/panc endoscopy	0.00	NA	NA	0.00	XXX
74330	TC	C	X-ray bile/panc endoscopy	0.00	NA	NA	0.00	XXX
74330	26	A	X-ray bile/panc endoscopy	0.90	0.29	0.29	0.06	XXX
74340		C	X-ray guide for GI tube	0.00	NA	NA	0.00	XXX
74340	TC	C	X-ray guide for GI tube	0.00	NA	NA	0.00	XXX
74340	26	A	X-ray guide for GI tube	0.54	0.17	0.17	0.04	XXX
74355		C	X-ray guide, intestinal tube	0.00	NA	NA	0.00	XXX
74355	TC	C	X-ray guide, intestinal tube	0.00	NA	NA	0.00	XXX
74355	26	A	X-ray guide, intestinal tube	0.76	0.25	0.25	0.05	XXX
74360		C	X-ray guide, GI dilation	0.00	NA	NA	0.00	XXX
74360	TC	C	X-ray guide, GI dilation	0.00	NA	NA	0.00	XXX
74360	26	A	X-ray guide, GI dilation	0.54	0.22	0.22	0.04	XXX
74363		C	X-ray, bile duct dilation	0.00	NA	NA	0.00	XXX
74363	TC	C	X-ray, bile duct dilation	0.00	NA	NA	0.00	XXX
74363	26	A	X-ray, bile duct dilation	0.88	0.26	0.26	0.06	XXX
74400		A	Contrst x-ray, urinary tract	0.49	2.27	NA	0.04	XXX
74400	TC	A	Contrst x-ray, urinary tract	0.00	2.12	NA	0.00	XXX
74400	26	A	Contrst x-ray, urinary tract	0.49	0.15	0.15	0.03	XXX
74410		A	Contrst x-ray, urinary tract	0.49	2.29	NA	0.04	XXX
74410	TC	A	Contrst x-ray, urinary tract	0.00	2.13	NA	0.00	XXX
74410	26	A	Contrst x-ray, urinary tract	0.49	0.15	0.15	0.03	XXX
74415		A	Contrst x-ray, urinary tract	0.49	2.87	NA	0.04	XXX
74415	TC	A	Contrst x-ray, urinary tract	0.00	2.72	NA	0.00	XXX
74415	26	A	Contrst x-ray, urinary tract	0.49	0.15	0.15	0.03	XXX
74420		C	Contrst x-ray, urinary tract	0.00	NA	NA	0.00	XXX
74420	TC	C	Contrst x-ray, urinary tract	0.00	NA	NA	0.00	XXX
74420	26	A	Contrst x-ray, urinary tract	0.36	0.11	0.11	0.03	XXX
74425		C	Contrst x-ray, urinary tract	0.00	NA	NA	0.00	XXX
74425	TC	C	Contrst x-ray, urinary tract	0.00	NA	NA	0.00	XXX
74425	26	A	Contrst x-ray, urinary tract	0.36	0.11	0.11	0.03	XXX
74430		A	Contrast x-ray, bladder	0.32	1.70	NA	0.02	XXX
74430	TC	A	Contrast x-ray, bladder	0.00	1.60	NA	0.00	XXX
74430	26	A	Contrast x-ray, bladder	0.32	0.10	0.10	0.02	XXX
74440		A	X-ray, male genital tract	0.38	1.75	NA	0.03	XXX
74440	TC	A	X-ray, male genital tract	0.00	1.62	NA	0.00	XXX
74440	26	A	X-ray, male genital tract	0.38	0.13	0.13	0.03	XXX

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CPT[1,2]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
74445		C	X-ray exam of penis	0.00	NA	NA	0.00	XXX
74445	TC	C	X-ray exam of penis	0.00	NA	NA	0.00	XXX
74445	26	A	X-ray exam of penis	1.14	0.37	0.37	0.08	XXX
74450		C	X-ray, urethra/bladder	0.00	NA	NA	0.00	XXX
74450	TC	C	X-ray, urethra/bladder	0.00	NA	NA	0.00	XXX
74450	26	A	X-ray, urethra/bladder	0.33	0.10	0.10	0.02	XXX
74455		A	X-ray, urethra/bladder	0.33	1.82	NA	0.02	XXX
74455	TC	A	X-ray, urethra/bladder	0.00	1.71	NA	0.00	XXX
74455	26	A	X-ray, urethra/bladder	0.33	0.11	0.11	0.02	XXX
74470		C	X-ray exam of kidney lesion	0.00	NA	NA	0.00	XXX
74470	TC	C	X-ray exam of kidney lesion	0.00	NA	NA	0.00	XXX
74470	26	A	X-ray exam of kidney lesion	0.54	0.16	0.16	0.04	XXX
74475		A	X-ray control, cath insert	0.54	1.32	NA	0.04	XXX
74475	TC	A	X-ray control, cath insert	0.00	1.16	NA	0.00	XXX
74475	26	A	X-ray control, cath insert	0.54	0.16	0.16	0.04	XXX
74480		A	X-ray control, cath insert	0.54	1.32	NA	0.04	XXX
74480	TC	A	X-ray control, cath insert	0.00	1.16	NA	0.00	XXX
74480	26	A	X-ray control, cath insert	0.54	0.16	0.16	0.04	XXX
74485		A	X-ray guide, GU dilation	0.54	1.35	NA	0.04	XXX
74485	TC	A	X-ray guide, GU dilation	0.00	1.19	NA	0.00	XXX
74485	26	A	X-ray guide, GU dilation	0.54	0.17	0.17	0.04	XXX
74710		A	X-ray measurement of pelvis	0.34	0.58	NA	0.02	XXX
74710	TC	A	X-ray measurement of pelvis	0.00	0.47	NA	0.00	XXX
74710	26	A	X-ray measurement of pelvis	0.34	0.10	0.10	0.02	XXX
74740		A	X-ray, female genital tract	0.38	1.59	NA	0.02	XXX
74740	TC	A	X-ray, female genital tract	0.00	1.47	NA	0.00	XXX
74740	26	A	X-ray, female genital tract	0.38	0.12	0.12	0.02	XXX
74742		C	X-ray, fallopian tube	0.00	NA	NA	0.00	XXX
74742	TC	C	X-ray, fallopian tube	0.00	NA	NA	0.00	XXX
74742	26	A	X-ray, fallopian tube	0.61	0.19	0.19	0.04	XXX
74775		C	X-ray exam of perineum	0.00	NA	NA	0.00	XXX
74775	TC	C	X-ray exam of perineum	0.00	NA	NA	0.00	XXX
74775	26	A	X-ray exam of perineum	0.62	0.19	0.19	0.04	XXX
75557		A	Cardiac mri for morph	2.35	6.11	NA	0.14	XXX
75557	TC	A	Cardiac mri for morph	0.00	5.37	NA	0.01	XXX
75557	26	A	Cardiac mri for morph	2.35	0.74	0.74	0.13	XXX
75558		N	Cardiac mri flow/velocity	2.60	8.79	NA	0.14	XXX
75558	TC	N	Cardiac mri flow/velocity	0.00	7.84	NA	0.01	XXX
75558	26	N	Cardiac mri flow/velocity	2.60	0.95	0.95	0.13	XXX
75559		A	Cardiac mri w/stress img	2.95	9.15	NA	0.18	XXX
75559	TC	A	Cardiac mri w/stress img	0.00	8.20	NA	0.01	XXX
75559	26	A	Cardiac mri w/stress img	2.95	0.95	0.95	0.17	XXX

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CPT[1,2]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
75560		N	Cardiac mri flow/vel/stress	3.00	11.98	NA	0.16	XXX
75560	TC	N	Cardiac mri flow/vel/stress	0.00	10.89	NA	0.01	XXX
75560	26	N	Cardiac mri flow/vel/stress	3.00	1.09	1.09	0.15	XXX
75561		A	Cardiac mri for morph w/dye	2.60	8.63	NA	0.15	XXX
75561	TC	A	Cardiac mri for morph w/dye	0.00	7.80	NA	0.01	XXX
75561	26	A	Cardiac mri for morph w/dye	2.60	0.83	0.83	0.14	XXX
75562		N	Card mri flow/vel w/dye	2.86	11.71	NA	0.15	XXX
75562	TC	N	Card mri flow/vel w/dye	0.00	10.66	NA	0.01	XXX
75562	26	N	Card mri flow/vel w/dye	2.86	1.04	1.04	0.15	XXX
75563		A	Card mri w/stress img & dye	3.00	10.40	NA	0.17	XXX
75563	TC	A	Card mri w/stress img & dye	0.00	9.43	NA	0.01	XXX
75563	26	A	Card mri w/stress img & dye	3.00	0.97	0.97	0.16	XXX
75564		N	Ht mri w/flo/vel/strs & dye	3.35	14.01	NA	0.18	XXX
75564	TC	N	Ht mri w/flo/vel/strs & dye	0.00	12.78	NA	0.01	XXX
75564	26	N	Ht mri w/flo/vel/strs & dye	3.35	1.22	1.22	0.17	XXX
75600		A	Contrast x-ray exam of aorta	0.49	4.32	NA	0.03	XXX
75600	TC	A	Contrast x-ray exam of aorta	0.00	4.16	NA	0.00	XXX
75600	26	A	Contrast x-ray exam of aorta	0.49	0.16	0.16	0.03	XXX
75605		A	Contrast x-ray exam of aorta	1.14	2.24	NA	0.09	XXX
75605	TC	A	Contrast x-ray exam of aorta	0.00	1.87	NA	0.00	XXX
75605	26	A	Contrast x-ray exam of aorta	1.14	0.36	0.36	0.08	XXX
75625		A	Contrast x-ray exam of aorta	1.14	2.29	NA	0.11	XXX
75625	TC	A	Contrast x-ray exam of aorta	0.00	1.94	NA	0.00	XXX
75625	26	A	Contrast x-ray exam of aorta	1.14	0.35	0.35	0.10	XXX
75630		A	X-ray aorta, leg arteries	1.79	2.51	NA	0.12	XXX
75630	TC	A	X-ray aorta, leg arteries	0.00	1.94	NA	0.01	XXX
75630	26	A	X-ray aorta, leg arteries	1.79	0.57	0.57	0.11	XXX
75635		A	Ct angio abdominal arteries	2.40	7.90	NA	0.16	XXX
75635	TC	A	Ct angio abdominal arteries	0.00	7.16	NA	0.01	XXX
75635	26	A	Ct angio abdominal arteries	2.40	0.74	0.74	0.15	XXX
75650		A	Artery x-rays, head & neck	1.49	2.41	NA	0.11	XXX
75650	TC	A	Artery x-rays, head & neck	0.00	1.94	NA	0.00	XXX
75650	26	A	Artery x-rays, head & neck	1.49	0.47	0.47	0.11	XXX
75658		A	Artery x-rays, arm	1.31	2.93	NA	0.10	XXX
75658	TC	A	Artery x-rays, arm	0.00	2.52	NA	0.00	XXX
75658	26	A	Artery x-rays, arm	1.31	0.41	0.41	0.10	XXX
75660		A	Artery x-rays, head & neck	1.31	2.89	NA	0.07	XXX
75660	TC	A	Artery x-rays, head & neck	0.00	2.45	NA	0.00	XXX
75660	26	A	Artery x-rays, head & neck	1.31	0.44	0.44	0.06	XXX
75662		A	Artery x-rays, head & neck	1.66	3.57	NA	0.10	XXX
75662	TC	A	Artery x-rays, head & neck	0.00	3.02	NA	0.00	XXX
75662	26	A	Artery x-rays, head & neck	1.66	0.56	0.56	0.09	XXX

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CPT[1]/HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
75665		A	Artery x-rays, head & neck	1.31	3.10	NA	0.12	XXX
75665	TC	A	Artery x-rays, head & neck	0.00	2.66	NA	0.00	XXX
75665	26	A	Artery x-rays, head & neck	1.31	0.44	0.44	0.12	XXX
75671		A	Artery x-rays, head & neck	1.66	3.85	NA	0.12	XXX
75671	TC	A	Artery x-rays, head & neck	0.00	3.31	NA	0.00	XXX
75671	26	A	Artery x-rays, head & neck	1.66	0.54	0.54	0.11	XXX
75676		A	Artery x-rays, neck	1.31	2.83	NA	0.12	XXX
75676	TC	A	Artery x-rays, neck	0.00	2.40	NA	0.00	XXX
75676	26	A	Artery x-rays, neck	1.31	0.43	0.43	0.12	XXX
75680		A	Artery x-rays, neck	1.66	3.32	NA	0.12	XXX
75680	TC	A	Artery x-rays, neck	0.00	2.78	NA	0.00	XXX
75680	26	A	Artery x-rays, neck	1.66	0.54	0.54	0.12	XXX
75685		A	Artery x-rays, spine	1.31	2.86	NA	0.10	XXX
75685	TC	A	Artery x-rays, spine	0.00	2.43	NA	0.00	XXX
75685	26	A	Artery x-rays, spine	1.31	0.43	0.43	0.10	XXX
75705		A	Artery x-rays, spine	2.18	3.20	NA	0.11	XXX
75705	TC	A	Artery x-rays, spine	0.00	2.49	NA	0.01	XXX
75705	26	A	Artery x-rays, spine	2.18	0.71	0.71	0.11	XXX
75710		A	Artery x-rays, arm/leg	1.14	2.83	NA	0.07	XXX
75710	TC	A	Artery x-rays, arm/leg	0.00	2.47	NA	0.00	XXX
75710	26	A	Artery x-rays, arm/leg	1.14	0.36	0.36	0.07	XXX
75716		A	Artery x-rays, arms/legs	1.31	3.57	NA	0.11	XXX
75716	TC	A	Artery x-rays, arms/legs	0.00	3.16	NA	0.00	XXX
75716	26	A	Artery x-rays, arms/legs	1.31	0.41	0.41	0.11	XXX
75722		A	Artery x-rays, kidney	1.14	2.52	NA	0.08	XXX
75722	TC	A	Artery x-rays, kidney	0.00	2.16	NA	0.00	XXX
75722	26	A	Artery x-rays, kidney	1.14	0.36	0.36	0.08	XXX
75724		A	Artery x-rays, kidneys	1.49	3.15	NA	0.08	XXX
75724	TC	A	Artery x-rays, kidneys	0.00	2.66	NA	0.00	XXX
75724	26	A	Artery x-rays, kidneys	1.49	0.49	0.49	0.08	XXX
75726		A	Artery x-rays, abdomen	1.14	2.72	NA	0.10	XXX
75726	TC	A	Artery x-rays, abdomen	0.00	2.38	NA	0.00	XXX
75726	26	A	Artery x-rays, abdomen	1.14	0.34	0.34	0.09	XXX
75731		A	Artery x-rays, adrenal gland	1.14	2.57	NA	0.06	XXX
75731	TC	A	Artery x-rays, adrenal gland	0.00	2.19	NA	0.00	XXX
75731	26	A	Artery x-rays, adrenal gland	1.14	0.38	0.38	0.05	XXX
75733		A	Artery x-rays, adrenals	1.31	3.37	NA	0.07	XXX
75733	TC	A	Artery x-rays, adrenals	0.00	2.93	NA	0.00	XXX
75733	26	A	Artery x-rays, adrenals	1.31	0.44	0.44	0.06	XXX
75736		A	Artery x-rays, pelvis	1.14	2.70	NA	0.08	XXX
75736	TC	A	Artery x-rays, pelvis	0.00	2.35	NA	0.00	XXX
75736	26	A	Artery x-rays, pelvis	1.14	0.35	0.35	0.07	XXX
75741		A	Artery x-rays, lung	1.31	2.20	NA	0.10	XXX
75741	TC	A	Artery x-rays, lung	0.00	1.81	NA	0.00	XXX
75741	26	A	Artery x-rays, lung	1.31	0.39	0.39	0.09	XXX
75743		A	Artery x-rays, lungs	1.66	2.57	NA	0.12	XXX
75743	TC	A	Artery x-rays, lungs	0.00	2.06	NA	0.00	XXX
75743	26	A	Artery x-rays, lungs	1.66	0.51	0.51	0.12	XXX
75746		A	Artery x-rays, lung	1.14	2.54	NA	0.08	XXX
75746	TC	A	Artery x-rays, lung	0.00	2.19	NA	0.00	XXX
75746	26	A	Artery x-rays, lung	1.14	0.35	0.35	0.08	XXX
75756		A	Artery x-rays, chest	1.14	2.71	NA	0.19	XXX
75756	TC	A	Artery x-rays, chest	0.00	2.36	NA	0.00	XXX
75756	26	A	Artery x-rays, chest	1.14	0.35	0.35	0.18	XXX
75774		A	Artery x-ray, each vessel	0.36	1.58	1.58	0.03	ZZZ
75774	TC	A	Artery x-ray, each vessel	0.00	1.47	1.47	0.00	ZZZ
75774	26	A	Artery x-ray, each vessel	0.36	0.11	0.11	0.03	ZZZ
75790		A	Visualize A-V shunt	1.84	2.39	NA	0.13	XXX
75790	TC	A	Visualize A-V shunt	0.00	1.82	NA	0.01	XXX
75790	26	A	Visualize A-V shunt	1.84	0.57	0.57	0.12	XXX
75801		C	Lymph vessel x-ray, arm/leg	0.00	NA	NA	0.00	XXX
75801	TC	C	Lymph vessel x-ray, arm/leg	0.00	NA	NA	0.00	XXX
75801	26	A	Lymph vessel x-ray, arm/leg	0.81	0.30	0.30	0.13	XXX
75803		C	Lymph vessel x-ray,arms/legs	0.00	NA	NA	0.00	XXX
75803	TC	C	Lymph vessel x-ray,arms/legs	0.00	NA	NA	0.00	XXX
75803	26	A	Lymph vessel x-ray,arms/legs	1.17	0.36	0.36	0.08	XXX
75805		C	Lymph vessel x-ray, trunk	0.00	NA	NA	0.00	XXX
75805	TC	C	Lymph vessel x-ray, trunk	0.00	NA	NA	0.00	XXX
75805	26	A	Lymph vessel x-ray, trunk	0.81	0.25	0.25	0.06	XXX
75807		C	Lymph vessel x-ray, trunk	0.00	NA	NA	0.00	XXX
75807	TC	C	Lymph vessel x-ray, trunk	0.00	NA	NA	0.00	XXX
75807	26	A	Lymph vessel x-ray, trunk	1.17	0.36	0.36	0.08	XXX
75809		A	Nonvascular shunt, x-ray	0.47	1.45	NA	0.04	XXX
75809	TC	A	Nonvascular shunt, x-ray	0.00	1.30	NA	0.00	XXX
75809	26	A	Nonvascular shunt, x-ray	0.47	0.15	0.15	0.04	XXX
75810		C	Vein x-ray, spleen/liver	0.00	NA	NA	0.00	XXX
75810	TC	C	Vein x-ray, spleen/liver	0.00	NA	NA	0.00	XXX
75810	26	A	Vein x-ray, spleen/liver	1.14	0.34	0.34	0.08	XXX
75820		A	Vein x-ray, arm/leg	0.70	1.94	NA	0.05	XXX
75820	TC	A	Vein x-ray, arm/leg	0.00	1.71	NA	0.00	XXX
75820	26	A	Vein x-ray, arm/leg	0.70	0.22	0.22	0.05	XXX
75822		A	Vein x-ray, arms/legs	1.06	2.30	NA	0.08	XXX
75822	TC	A	Vein x-ray, arms/legs	0.00	1.97	NA	0.00	XXX
75822	26	A	Vein x-ray, arms/legs	1.06	0.32	0.32	0.08	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
75825		A	Vein x-ray, trunk	1.14	2.09	NA	0.09	XXX
75825	TC	A	Vein x-ray, trunk	0.00	1.75	NA	0.00	XXX
75825	26	A	Vein x-ray, trunk	1.14	0.34	0.34	0.09	XXX
75827		A	Vein x-ray, chest	1.14	2.21	NA	0.08	XXX
75827	TC	A	Vein x-ray, chest	0.00	1.86	NA	0.00	XXX
75827	26	A	Vein x-ray, chest	1.14	0.35	0.35	0.08	XXX
75831		A	Vein x-ray, kidney	1.14	2.21	NA	0.21	XXX
75831	TC	A	Vein x-ray, kidney	0.00	1.87	NA	0.00	XXX
75831	26	A	Vein x-ray, kidney	1.14	0.34	0.34	0.20	XXX
75833		A	Vein x-ray, kidneys	1.49	2.76	NA	0.11	XXX
75833	TC	A	Vein x-ray, kidneys	0.00	2.32	NA	0.00	XXX
75833	26	A	Vein x-ray, kidneys	1.49	0.44	0.44	0.10	XXX
75840		A	Vein x-ray, adrenal gland	1.14	2.07	NA	0.21	XXX
75840	TC	A	Vein x-ray, adrenal gland	0.00	1.76	NA	0.00	XXX
75840	26	A	Vein x-ray, adrenal gland	1.14	0.31	0.31	0.20	XXX
75842		A	Vein x-ray, adrenal glands	1.49	2.71	NA	0.11	XXX
75842	TC	A	Vein x-ray, adrenal glands	0.00	2.24	NA	0.00	XXX
75842	26	A	Vein x-ray, adrenal glands	1.49	0.46	0.46	0.10	XXX
75860		A	Vein x-ray, neck	1.14	2.17	NA	0.09	XXX
75860	TC	A	Vein x-ray, neck	0.00	1.81	NA	0.00	XXX
75860	26	A	Vein x-ray, neck	1.14	0.36	0.36	0.09	XXX
75870		A	Vein x-ray, skull	1.14	2.32	NA	0.08	XXX
75870	TC	A	Vein x-ray, skull	0.00	1.94	NA	0.00	XXX
75870	26	A	Vein x-ray, skull	1.14	0.38	0.38	0.08	XXX
75872		A	Vein x-ray, skull	1.14	4.62	NA	0.08	XXX
75872	TC	A	Vein x-ray, skull	0.00	4.09	NA	0.00	XXX
75872	26	A	Vein x-ray, skull	1.14	0.53	0.53	0.08	XXX
75880		A	Vein x-ray, eye socket	0.70	2.03	NA	0.05	XXX
75880	TC	A	Vein x-ray, eye socket	0.00	1.81	NA	0.00	XXX
75880	26	A	Vein x-ray, eye socket	0.70	0.22	0.22	0.05	XXX
75885		A	Vein x-ray, liver	1.44	2.27	NA	0.10	XXX
75885	TC	A	Vein x-ray, liver	0.00	1.84	NA	0.00	XXX
75885	26	A	Vein x-ray, liver	1.44	0.43	0.43	0.10	XXX
75887		A	Vein x-ray, liver	1.44	2.35	NA	0.08	XXX
75887	TC	A	Vein x-ray, liver	0.00	1.90	NA	0.00	XXX
75887	26	A	Vein x-ray, liver	1.44	0.45	0.45	0.08	XXX
75889		A	Vein x-ray, liver	1.14	2.17	NA	0.08	XXX
75889	TC	A	Vein x-ray, liver	0.00	1.83	NA	0.00	XXX
75889	26	A	Vein x-ray, liver	1.14	0.34	0.34	0.08	XXX
75891		A	Vein x-ray, liver	1.14	2.17	NA	0.08	XXX
75891	TC	A	Vein x-ray, liver	0.00	1.83	NA	0.00	XXX
75891	26	A	Vein x-ray, liver	1.14	0.34	0.34	0.08	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
75893		A	Venous sampling by catheter	0.54	1.95	NA	0.03	XXX
75893	TC	A	Venous sampling by catheter	0.00	1.78	NA	0.00	XXX
75893	26	A	Venous sampling by catheter	0.54	0.16	0.16	0.03	XXX
75894		C	X-rays, transcath therapy	0.00	NA	NA	0.00	XXX
75894	TC	C	X-rays, transcath therapy	0.00	NA	NA	0.00	XXX
75894	26	A	X-rays, transcath therapy	1.31	0.40	0.40	0.12	XXX
75896		C	X-rays, transcath therapy	0.00	NA	NA	0.00	XXX
75896	TC	C	X-rays, transcath therapy	0.00	NA	NA	0.00	XXX
75896	26	A	X-rays, transcath therapy	1.31	0.41	0.41	0.12	XXX
75898		C	Follow-up angiography	0.00	NA	NA	0.00	XXX
75898	TC	C	Follow-up angiography	0.00	NA	NA	0.00	XXX
75898	26	A	Follow-up angiography	1.65	0.52	0.52	0.15	XXX
75900		C	Intravascular cath exchange	0.00	NA	NA	0.00	XXX
75900	TC	C	Intravascular cath exchange	0.00	NA	NA	0.00	XXX
75900	26	A	Intravascular cath exchange	0.49	0.15	0.15	0.05	XXX
75901		A	Remove cva device obstruct	0.49	3.89	NA	0.04	XXX
75901	TC	A	Remove cva device obstruct	0.00	3.74	NA	0.00	XXX
75901	26	A	Remove cva device obstruct	0.49	0.15	0.15	0.04	XXX
75902		A	Remove cva lumen obstruct	0.39	1.55	NA	0.05	XXX
75902	TC	A	Remove cva lumen obstruct	0.00	1.43	NA	0.00	XXX
75902	26	A	Remove cva lumen obstruct	0.39	0.12	0.12	0.04	XXX
75940		C	X-ray placement, vein filter	0.00	NA	NA	0.00	XXX
75940	TC	C	X-ray placement, vein filter	0.00	NA	NA	0.00	XXX
75940	26	A	X-ray placement, vein filter	0.54	0.16	0.16	0.05	XXX
75945		C	Intravascular us	0.00	NA	NA	0.00	XXX
75945	TC	C	Intravascular us	0.00	NA	NA	0.00	XXX
75945	26	A	Intravascular us	0.40	0.12	0.12	0.05	XXX
75946		C	Intravascular us add-on	0.00	NA	0.00	0.00	ZZZ
75946	TC	C	Intravascular us add-on	0.00	NA	0.00	0.00	ZZZ
75946	26	A	Intravascular us add-on	0.40	0.12	0.12	0.06	ZZZ
75952		C	Endovasc repair abdom aorta	0.00	NA	NA	0.00	XXX
75952	TC	C	Endovasc repair abdom aorta	0.00	NA	NA	0.00	XXX
75952	26	A	Endovasc repair abdom aorta	4.49	1.36	1.36	0.66	XXX
75953		C	Abdom aneurysm endovas rpr	0.00	NA	NA	0.00	XXX
75953	TC	C	Abdom aneurysm endovas rpr	0.00	NA	NA	0.00	XXX
75953	26	A	Abdom aneurysm endovas rpr	1.36	0.41	0.41	0.20	XXX
75954		C	Iliac aneurysm endovas rpr	0.00	NA	NA	0.00	XXX
75954	TC	C	Iliac aneurysm endovas rpr	0.00	NA	NA	0.00	XXX
75954	26	A	Iliac aneurysm endovas rpr	2.25	0.68	0.68	0.32	XXX
75956		C	Xray, endovasc thor ao repr	0.00	NA	NA	0.00	XXX
75956	TC	C	Xray, endovasc thor ao repr	0.00	NA	NA	0.00	XXX
75956	26	A	Xray, endovasc thor ao repr	7.00	2.07	2.07	1.10	XXX

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CPT[1,7] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
75957		C	Xray, endovasc thor ao repr	0.00	NA	NA	0.00	XXX
75957	TC	C	Xray, endovasc thor ao repr	0.00	NA	NA	0.00	XXX
75957	26	A	Xray, endovasc thor ao repr	6.00	1.77	1.77	0.93	XXX
75958		C	Xray, place prox ext thor ao	0.00	NA	NA	0.00	XXX
75958	TC	C	Xray, place prox ext thor ao	0.00	NA	NA	0.00	XXX
75958	26	A	Xray, place prox ext thor ao	4.00	1.17	1.17	0.62	XXX
75959		C	Xray, place dist ext thor ao	0.00	NA	NA	0.00	XXX
75959	TC	C	Xray, place dist ext thor ao	0.00	NA	NA	0.00	XXX
75959	26	A	Xray, place dist ext thor ao	3.50	0.95	0.95	0.63	XXX
75960		A	Transcath iv stent rs&i	0.82	1.72	NA	0.06	XXX
75960	TC	A	Transcath iv stent rs&i	0.00	1.46	NA	0.00	XXX
75960	26	A	Transcath iv stent rs&i	0.82	0.26	0.26	0.06	XXX
75961		A	Retrieval, broken catheter	4.24	3.52	NA	0.31	XXX
75961	TC	A	Retrieval, broken catheter	0.00	2.24	NA	0.01	XXX
75961	26	A	Retrieval, broken catheter	4.24	1.28	1.28	0.29	XXX
75962		A	Repair arterial blockage	0.54	2.44	NA	0.04	XXX
75962	TC	A	Repair arterial blockage	0.00	2.27	NA	0.00	XXX
75962	26	A	Repair arterial blockage	0.54	0.17	0.17	0.04	XXX
75964		A	Repair artery blockage, each	0.36	1.47	1.47	0.04	ZZZ
75964	TC	A	Repair artery blockage, each	0.00	1.36	1.36	0.00	ZZZ
75964	26	A	Repair artery blockage, each	0.36	0.11	0.11	0.04	ZZZ
75966		A	Repair arterial blockage	1.31	2.68	NA	0.09	XXX
75966	TC	A	Repair arterial blockage	0.00	2.26	NA	0.00	XXX
75966	26	A	Repair arterial blockage	1.31	0.42	0.42	0.08	XXX
75968		A	Repair artery blockage, each	0.36	1.36	1.36	0.02	ZZZ
75968	TC	A	Repair artery blockage, each	0.00	1.24	1.24	0.00	ZZZ
75968	26	A	Repair artery blockage, each	0.36	0.11	0.11	0.02	ZZZ
75970		C	Vascular biopsy	0.00	NA	NA	0.00	XXX
75970	TC	C	Vascular biopsy	0.00	NA	NA	0.00	XXX
75970	26	A	Vascular biopsy	0.83	0.25	0.25	0.06	XXX
75978		A	Repair venous blockage	0.54	2.52	NA	0.04	XXX
75978	TC	A	Repair venous blockage	0.00	2.35	NA	0.00	XXX
75978	26	A	Repair venous blockage	0.54	0.17	0.17	0.03	XXX
75980		C	Contrast xray exam bile duct	0.00	NA	NA	0.00	XXX
75980	TC	C	Contrast xray exam bile duct	0.00	NA	NA	0.00	XXX
75980	26	A	Contrast xray exam bile duct	1.44	0.43	0.43	0.10	XXX
75982		C	Contrast xray exam bile duct	0.00	NA	NA	0.00	XXX
75982	TC	C	Contrast xray exam bile duct	0.00	NA	NA	0.00	XXX
75982	26	A	Contrast xray exam bile duct	1.44	0.43	0.43	0.11	XXX
75984		A	Xray control catheter change	0.72	1.51	NA	0.05	XXX
75984	TC	A	Xray control catheter change	0.00	1.29	NA	0.00	XXX
75984	26	A	Xray control catheter change	0.72	0.22	0.22	0.05	XXX
75989		A	Abscess drainage under x-ray	1.19	1.48	NA	0.08	XXX
75989	TC	A	Abscess drainage under x-ray	0.00	1.12	NA	0.00	XXX
75989	26	A	Abscess drainage under x-ray	1.19	0.36	0.36	0.08	XXX
75992		C	Atherectomy, x-ray exam	0.00	NA	NA	0.00	XXX
75992	TC	C	Atherectomy, x-ray exam	0.00	NA	NA	0.00	XXX
75992	26	A	Atherectomy, x-ray exam	0.54	0.17	0.17	0.05	XXX
75993		C	Atherectomy, x-ray exam	0.00	NA	NA	0.00	ZZZ
75993	TC	C	Atherectomy, x-ray exam	0.00	NA	NA	0.00	ZZZ
75993	26	A	Atherectomy, x-ray exam	0.36	0.11	0.11	0.04	ZZZ
75994		C	Atherectomy, x-ray exam	0.00	NA	NA	0.00	XXX
75994	TC	C	Atherectomy, x-ray exam	0.00	NA	NA	0.00	XXX
75994	26	A	Atherectomy, x-ray exam	1.31	0.31	0.31	0.10	XXX
75995		C	Atherectomy, x-ray exam	0.00	NA	NA	0.00	XXX
75995	TC	C	Atherectomy, x-ray exam	0.00	NA	NA	0.00	XXX
75995	26	A	Atherectomy, x-ray exam	1.31	0.44	0.44	0.07	XXX
75996		C	Atherectomy, x-ray exam	0.00	NA	NA	0.00	ZZZ
75996	TC	C	Atherectomy, x-ray exam	0.00	NA	NA	0.00	ZZZ
75996	26	A	Atherectomy, x-ray exam	0.36	0.10	0.10	0.06	XXX
76000		A	Fluoroscope examination	0.17	2.74	NA	0.02	XXX
76000	TC	A	Fluoroscope examination	0.00	2.68	NA	0.00	XXX
76000	26	A	Fluoroscope examination	0.17	0.06	0.06	0.02	XXX
76001		C	Fluoroscope exam, extensive	0.00	NA	NA	0.00	XXX
76001	TC	C	Fluoroscope exam, extensive	0.00	NA	NA	0.00	XXX
76001	26	A	Fluoroscope exam, extensive	0.67	0.24	0.24	0.07	XXX
76010		A	X-ray, nose to rectum	0.18	0.47	NA	0.01	XXX
76010	TC	A	X-ray, nose to rectum	0.00	0.42	NA	0.00	XXX
76010	26	A	X-ray, nose to rectum	0.18	0.05	0.05	0.01	XXX
76080		A	X-ray exam of fistula	0.54	0.98	NA	0.03	XXX
76080	TC	A	X-ray exam of fistula	0.00	0.82	NA	0.00	XXX
76080	26	A	X-ray exam of fistula	0.54	0.16	0.16	0.03	XXX
76098		A	X-ray exam, breast specimen	0.16	0.29	NA	0.01	XXX
76098	TC	A	X-ray exam, breast specimen	0.00	0.24	NA	0.00	XXX
76098	26	A	X-ray exam, breast specimen	0.16	0.05	0.05	0.01	XXX
76100		A	X-ray exam of body section	0.58	3.46	NA	0.05	XXX
76100	TC	A	X-ray exam of body section	0.00	3.21	NA	0.00	XXX
76100	26	A	X-ray exam of body section	0.58	0.24	0.24	0.05	XXX
76101		A	Complex body section x-ray	0.58	5.23	NA	0.02	XXX
76101	TC	A	Complex body section x-ray	0.00	4.92	NA	0.00	XXX
76101	26	A	Complex body section x-ray	0.58	0.32	0.32	0.01	XXX
76102		A	Complex body section x-rays	0.58	7.62	NA	0.02	XXX
76102	TC	A	Complex body section x-rays	0.00	7.28	NA	0.00	XXX
76102	26	A	Complex body section x-rays	0.58	0.34	0.34	0.02	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
76120		A	Cine/video x-rays	0.38	1.52	NA	0.04	XXX
76120	TC	A	Cine/video x-rays	0.00	1.39	NA	0.00	XXX
76120	26	A	Cine/video x-rays	0.38	0.13	0.13	0.04	XXX
76125		C	Cine/video x-rays add-on	0.00	NA	NA	0.00	ZZZ
76125	TC	C	Cine/video x-rays add-on	0.00	NA	NA	0.00	ZZZ
76125	26	A	Cine/video x-rays add-on	0.27	0.09	0.09	0.02	ZZZ
76140		I	X-ray consultation	0.00	0.00	0.00	0.00	XXX
76150		A	X-ray exam, dry process	0.00	0.56	NA	0.00	XXX
76350		C	Special x-ray contrast study	0.00	NA	NA	0.00	XXX
76376		A	3d render w/o postprocess	0.20	1.25	NA	0.01	XXX
76376	TC	A	3d render w/o postprocess	0.00	1.19	NA	0.00	XXX
76376	26	A	3d render w/o postprocess	0.20	0.06	0.06	0.01	XXX
76377		A	3d rendering w/postprocess	0.79	1.22	NA	0.05	XXX
76377	TC	A	3d rendering w/postprocess	0.00	0.97	NA	0.00	XXX
76377	26	A	3d rendering w/postprocess	0.79	0.25	0.25	0.05	XXX
76380		A	CAT scan follow-up study	0.98	2.78	NA	0.06	XXX
76380	TC	A	CAT scan follow-up study	0.00	2.47	NA	0.00	XXX
76380	26	A	CAT scan follow-up study	0.98	0.31	0.31	0.06	XXX
76390		N	Mr spectroscopy	1.40	6.42	NA	0.07	XXX
76390	TC	N	Mr spectroscopy	0.00	5.91	NA	0.00	XXX
76390	26	N	Mr spectroscopy	1.40	0.51	0.51	0.07	XXX
76496		C	Fluoroscopic procedure	0.00	0.00	NA	0.00	XXX
76496	TC	C	Fluoroscopic procedure	0.00	0.00	NA	0.00	XXX
76496	26	C	Fluoroscopic procedure	0.00	0.00	0.00	0.00	XXX
76497		C	Ct procedure	0.00	0.00	NA	0.00	XXX
76497	TC	C	Ct procedure	0.00	0.00	NA	0.00	XXX
76497	26	C	Ct procedure	0.00	0.00	0.00	0.00	XXX
76498		C	Mri procedure	0.00	0.00	NA	0.00	XXX
76498	TC	C	Mri procedure	0.00	0.00	NA	0.00	XXX
76498	26	C	Mri procedure	0.00	0.00	0.00	0.00	XXX
76499		C	Radiographic procedure	0.00	0.00	NA	0.00	XXX
76499	TC	C	Radiographic procedure	0.00	0.00	NA	0.00	XXX
76499	26	C	Radiographic procedure	0.00	0.00	0.00	0.00	XXX
76506		A	Echo exam of head	0.63	2.53	NA	0.03	XXX
76506	TC	A	Echo exam of head	0.00	2.32	NA	0.00	XXX
76506	26	A	Echo exam of head	0.63	0.21	0.21	0.03	XXX
76510		A	Ophth us, b & quant a	1.55	2.82	NA	0.05	XXX
76510	TC	A	Ophth us, b & quant a	0.00	1.90	NA	0.00	XXX
76510	26	A	Ophth us, b & quant a	1.55	0.92	0.92	0.04	XXX
76511		A	Ophth us, quant a only	0.94	1.66	NA	0.03	XXX
76511	TC	A	Ophth us, quant a only	0.00	1.14	NA	0.00	XXX
76511	26	A	Ophth us, quant a only	0.94	0.52	0.52	0.02	XXX

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76512		A	Ophth us, b w/non-quant a	0.94	1.46	NA	0.03	XXX
76512	TC	A	Ophth us, b w/non-quant a	0.00	0.93	NA	0.00	XXX
76512	26	A	Ophth us, b w/non-quant a	0.94	0.54	0.54	0.03	XXX
76513		A	Echo exam of eye, water bath	0.66	1.70	NA	0.02	XXX
76513	TC	A	Echo exam of eye, water bath	0.00	1.38	NA	0.00	XXX
76513	26	A	Echo exam of eye, water bath	0.66	0.32	0.32	0.02	XXX
76514		A	Echo exam of eye, thickness	0.17	0.21	NA	0.00	XXX
76514	TC	A	Echo exam of eye, thickness	0.00	0.12	NA	0.00	XXX
76514	26	A	Echo exam of eye, thickness	0.17	0.09	0.09	0.00	XXX
76516		A	Echo exam of eye	0.54	1.40	NA	0.02	XXX
76516	TC	A	Echo exam of eye	0.00	1.10	NA	0.00	XXX
76516	26	A	Echo exam of eye	0.54	0.30	0.30	0.01	XXX
76519		A	Echo exam of eye	0.54	1.54	NA	0.02	XXX
76519	TC	A	Echo exam of eye	0.00	1.23	NA	0.00	XXX
76519	26	A	Echo exam of eye	0.54	0.32	0.32	0.01	XXX
76529		A	Echo exam of eye	0.57	1.42	NA	0.02	XXX
76529	TC	A	Echo exam of eye	0.00	1.08	NA	0.00	XXX
76529	26	A	Echo exam of eye	0.57	0.34	0.34	0.02	XXX
76536		A	Us exam of head and neck	0.56	2.48	NA	0.03	XXX
76536	TC	A	Us exam of head and neck	0.00	2.30	NA	0.00	XXX
76536	26	A	Us exam of head and neck	0.56	0.18	0.18	0.03	XXX
76604		A	Us exam, chest	0.55	1.63	NA	0.04	XXX
76604	TC	A	Us exam, chest	0.00	1.47	NA	0.00	XXX
76604	26	A	Us exam, chest	0.55	0.17	0.17	0.04	XXX
76645		A	Us exam, breast(s)	0.54	1.89	NA	0.05	XXX
76645	TC	A	Us exam, breast(s)	0.00	1.73	NA	0.00	XXX
76645	26	A	Us exam, breast(s)	0.54	0.17	0.17	0.04	XXX
76700		A	Us exam, abdom, complete	0.81	2.73	NA	0.05	XXX
76700	TC	A	Us exam, abdom, complete	0.00	2.47	NA	0.00	XXX
76700	26	A	Us exam, abdom, complete	0.81	0.25	0.25	0.05	XXX
76705		A	Echo exam of abdomen	0.59	2.09	NA	0.04	XXX
76705	TC	A	Echo exam of abdomen	0.00	1.91	NA	0.00	XXX
76705	26	A	Echo exam of abdomen	0.59	0.18	0.18	0.04	XXX
76770		A	Us exam abdo back wall, comp	0.74	2.58	NA	0.05	XXX
76770	TC	A	Us exam abdo back wall, comp	0.00	2.35	NA	0.00	XXX
76770	26	A	Us exam abdo back wall, comp	0.74	0.23	0.23	0.05	XXX
76775		A	Us exam abdo back wall, lim	0.58	2.10	NA	0.04	XXX
76775	TC	A	Us exam abdo back wall, lim	0.00	1.92	NA	0.00	XXX
76775	26	A	Us exam abdo back wall, lim	0.58	0.18	0.18	0.04	XXX
76776		A	Us exam k transpl w/doppler	0.76	3.04	NA	0.05	XXX
76776	TC	A	Us exam k transpl w/doppler	0.00	2.81	NA	0.00	XXX
76776	26	A	Us exam k transpl w/doppler	0.76	0.23	0.23	0.05	XXX

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CPT[1,2] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
76800		A	Us exam, spinal canal	1.13	2.42	NA	0.06	XXX
76800	TC	A	Us exam, spinal canal	0.00	2.01	NA	0.00	XXX
76800	26	A	Us exam, spinal canal	1.13	0.41	0.41	0.06	XXX
76801		A	Ob us < 14 wks, single fetus	0.99	2.24	NA	0.05	XXX
76801	TC	A	Ob us < 14 wks, single fetus	0.00	1.91	NA	0.00	XXX
76801	26	A	Ob us < 14 wks, single fetus	0.99	0.33	0.33	0.05	XXX
76802		A	Ob us < 14 wks, add£l fetus	0.83	0.93	0.93	0.04	ZZZ
76802	TC	A	Ob us < 14 wks, add£l fetus	0.00	0.64	0.64	0.00	ZZZ
76802	26	A	Ob us < 14 wks, add£l fetus	0.83	0.29	0.29	0.04	ZZZ
76805		A	Ob us >/= 14 wks, sngl fetus	0.99	2.78	NA	0.05	XXX
76805	TC	A	Ob us >/= 14 wks, sngl fetus	0.00	2.43	NA	0.00	XXX
76805	26	A	Ob us >/= 14 wks, sngl fetus	0.99	0.34	0.34	0.05	XXX
76810		A	Ob us >/= 14 wks, addl fetus	0.98	1.55	1.55	0.05	ZZZ
76810	TC	A	Ob us >/= 14 wks, addl fetus	0.00	1.21	1.21	0.00	ZZZ
76810	26	A	Ob us >/= 14 wks, addl fetus	0.98	0.34	0.34	0.04	ZZZ
76811		A	Ob us, detailed, sngl fetus	1.90	2.94	NA	0.09	XXX
76811	TC	A	Ob us, detailed, sngl fetus	0.00	2.22	NA	0.01	XXX
76811	26	A	Ob us, detailed, sngl fetus	1.90	0.71	0.71	0.08	XXX
76812		A	Ob us, detailed, addl fetus	1.78	3.72	3.72	0.08	ZZZ
76812	TC	A	Ob us, detailed, addl fetus	0.00	3.05	3.05	0.01	ZZZ
76812	26	A	Ob us, detailed, addl fetus	1.78	0.67	0.67	0.08	ZZZ
76813		A	Ob us nuchal meas, 1 gest	1.18	2.07	NA	0.06	XXX
76813	TC	A	Ob us nuchal meas, 1 gest	0.00	1.63	NA	0.00	XXX
76813	26	A	Ob us nuchal meas, 1 gest	1.18	0.44	0.44	0.05	XXX
76814		A	Ob us nuchal meas, add-on	0.99	1.15	NA	0.05	XXX
76814	TC	A	Ob us nuchal meas, add-on	0.00	0.77	NA	0.00	XXX
76814	26	A	Ob us nuchal meas, add-on	0.99	0.38	0.38	0.04	XXX
76815		A	Ob us, limited, fetus(s)	0.65	1.65	NA	0.03	XXX
76815	TC	A	Ob us, limited, fetus(s)	0.00	1.43	NA	0.00	XXX
76815	26	A	Ob us, limited, fetus(s)	0.65	0.22	0.22	0.03	XXX
76816		A	Ob us, follow-up, per fetus	0.85	2.20	NA	0.04	XXX
76816	TC	A	Ob us, follow-up, per fetus	0.00	1.89	NA	0.00	XXX
76816	26	A	Ob us, follow-up, per fetus	0.85	0.31	0.31	0.04	XXX
76817		A	Transvaginal us, obstetric	0.75	1.84	NA	0.04	XXX
76817	TC	A	Transvaginal us, obstetric	0.00	1.59	NA	0.00	XXX
76817	26	A	Transvaginal us, obstetric	0.75	0.26	0.26	0.03	XXX
76818		A	Fetal biophys profile w/nst	1.05	2.09	NA	0.05	XXX
76818	TC	A	Fetal biophys profile w/nst	0.00	1.70	NA	0.00	XXX
76818	26	A	Fetal biophys profile w/nst	1.05	0.39	0.39	0.05	XXX
76819		A	Fetal biophys profil w/o nst	0.77	1.51	NA	0.04	XXX
76819	TC	A	Fetal biophys profil w/o nst	0.00	1.24	NA	0.00	XXX
76819	26	A	Fetal biophys profil w/o nst	0.77	0.27	0.27	0.03	XXX
76820		A	Umbilical artery echo	0.50	0.56	NA	0.02	XXX
76820	TC	A	Umbilical artery echo	0.00	0.38	NA	0.00	XXX
76820	26	A	Umbilical artery echo	0.50	0.19	0.19	0.02	XXX
76821		A	Middle cerebral artery echo	0.70	1.73	NA	0.03	XXX
76821	TC	A	Middle cerebral artery echo	0.00	1.47	NA	0.00	XXX
76821	26	A	Middle cerebral artery echo	0.70	0.26	0.26	0.03	XXX
76825		A	Echo exam of fetal heart	1.67	4.00	NA	0.08	XXX
76825	TC	A	Echo exam of fetal heart	0.00	3.40	NA	0.00	XXX
76825	26	A	Echo exam of fetal heart	1.67	0.61	0.61	0.07	XXX
76826		A	Echo exam of fetal heart	0.83	2.52	NA	0.04	XXX
76826	TC	A	Echo exam of fetal heart	0.00	2.21	NA	0.00	XXX
76826	26	A	Echo exam of fetal heart	0.83	0.30	0.30	0.04	XXX
76827		A	Echo exam of fetal heart	0.58	1.01	NA	0.03	XXX
76827	TC	A	Echo exam of fetal heart	0.00	0.80	NA	0.00	XXX
76827	26	A	Echo exam of fetal heart	0.58	0.21	0.21	0.03	XXX
76828		A	Echo exam of fetal heart	0.56	0.63	NA	0.03	XXX
76828	TC	A	Echo exam of fetal heart	0.00	0.42	NA	0.00	XXX
76828	26	A	Echo exam of fetal heart	0.56	0.21	0.21	0.03	XXX
76830		A	Transvaginal us, non-ob	0.69	2.48	NA	0.04	XXX
76830	TC	A	Transvaginal us, non-ob	0.00	2.26	NA	0.00	XXX
76830	26	A	Transvaginal us, non-ob	0.69	0.23	0.23	0.04	XXX
76831		A	Echo exam, uterus	0.72	2.50	NA	0.04	XXX
76831	TC	A	Echo exam, uterus	0.00	2.23	NA	0.00	XXX
76831	26	A	Echo exam, uterus	0.72	0.27	0.27	0.03	XXX
76856		A	Us exam, pelvic, complete	0.69	2.46	NA	0.04	XXX
76856	TC	A	Us exam, pelvic, complete	0.00	2.24	NA	0.00	XXX
76856	26	A	Us exam, pelvic, complete	0.69	0.22	0.22	0.04	XXX
76857		A	Us exam, pelvic, limited	0.38	2.02	NA	0.03	XXX
76857	TC	A	Us exam, pelvic, limited	0.00	1.90	NA	0.00	XXX
76857	26	A	Us exam, pelvic, limited	0.38	0.12	0.12	0.03	XXX
76870		A	Us exam, scrotum	0.64	2.46	NA	0.05	XXX
76870	TC	A	Us exam, scrotum	0.00	2.27	NA	0.00	XXX
76870	26	A	Us exam, scrotum	0.64	0.20	0.20	0.04	XXX
76872		A	Us, transrectal	0.69	2.64	NA	0.05	XXX
76872	TC	A	Us, transrectal	0.00	2.42	NA	0.00	XXX
76872	26	A	Us, transrectal	0.69	0.23	0.23	0.05	XXX
76873		A	Echograp trans r, pros study	1.55	2.94	NA	0.10	XXX
76873	TC	A	Echograp trans r, pros study	0.00	2.39	NA	0.00	XXX
76873	26	A	Echograp trans r, pros study	1.55	0.55	0.55	0.10	XXX
76880		A	Us exam, extremity	0.59	3.04	NA	0.03	XXX
76880	TC	A	Us exam, extremity	0.00	2.86	NA	0.00	XXX
76880	26	A	Us exam, extremity	0.59	0.18	0.18	0.03	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
76885		A	Us exam infant hips, dynamic	0.74	2.97	NA	0.05	XXX
76885	TC	A	Us exam infant hips, dynamic	0.00	2.73	NA	0.00	XXX
76885	26	A	Us exam infant hips, dynamic	0.74	0.23	0.23	0.05	XXX
76886		A	Us exam infant hips, static	0.62	2.59	NA	0.03	XXX
76886	TC	A	Us exam infant hips, static	0.00	2.34	NA	0.00	XXX
76886	26	A	Us exam infant hips, static	0.62	0.25	0.25	0.03	XXX
76930		A	Echo guide, cardiocentesis	0.67	1.43	NA	0.03	XXX
76930	TC	A	Echo guide, cardiocentesis	0.00	1.21	NA	0.00	XXX
76930	26	A	Echo guide, cardiocentesis	0.67	0.22	0.22	0.03	XXX
76932		C	Echo guide for heart biopsy	0.00	NA	NA	0.00	XXX
76932	TC	C	Echo guide for heart biopsy	0.00	NA	NA	0.00	XXX
76932	26	A	Echo guide for heart biopsy	0.67	0.23	0.23	0.04	XXX
76936		A	Echo guide for artery repair	1.99	5.46	NA	0.22	XXX
76936	TC	A	Echo guide for artery repair	0.00	4.85	NA	0.01	XXX
76936	26	A	Echo guide for artery repair	1.99	0.62	0.62	0.21	XXX
76937		A	Us guide, vascular access	0.30	0.58	0.58	0.02	ZZZ
76937	TC	A	Us guide, vascular access	0.00	0.49	0.49	0.00	ZZZ
76937	26	A	Us guide, vascular access	0.30	0.09	0.09	0.02	ZZZ
76940		C	Us guide, tissue ablation	0.00	NA	NA	0.00	XXX
76940	TC	C	Us guide, tissue ablation	0.00	NA	NA	0.00	XXX
76940	26	A	Us guide, tissue ablation	2.00	0.67	0.67	0.21	XXX
76941		C	Echo guide for transfusion	0.00	NA	NA	0.00	XXX
76941	TC	C	Echo guide for transfusion	0.00	NA	NA	0.00	XXX
76941	26	A	Echo guide for transfusion	1.34	0.51	0.51	0.10	XXX
76942		A	Echo guide for biopsy	0.67	4.25	NA	0.05	XXX
76942	TC	A	Echo guide for biopsy	0.00	4.03	NA	0.00	XXX
76942	26	A	Echo guide for biopsy	0.67	0.21	0.21	0.04	XXX
76945		C	Echo guide, villus sampling	0.00	NA	NA	0.00	XXX
76945	TC	C	Echo guide, villus sampling	0.00	NA	NA	0.00	XXX
76945	26	A	Echo guide, villus sampling	0.67	0.26	0.26	0.03	XXX
76946		A	Echo guide for amniocentesis	0.38	0.44	NA	0.02	XXX
76946	TC	A	Echo guide for amniocentesis	0.00	0.30	NA	0.00	XXX
76946	26	A	Echo guide for amniocentesis	0.38	0.14	0.14	0.02	XXX
76948		A	Echo guide, ova aspiration	0.38	0.53	NA	0.03	XXX
76948	TC	A	Echo guide, ova aspiration	0.00	0.39	NA	0.00	XXX
76948	26	A	Echo guide, ova aspiration	0.38	0.14	0.14	0.03	XXX
76950		A	Echo guidance radiotherapy	0.58	1.11	NA	0.04	XXX
76950	TC	A	Echo guidance radiotherapy	0.00	0.89	NA	0.00	XXX
76950	26	A	Echo guidance radiotherapy	0.58	0.22	0.22	0.04	XXX
76965		A	Echo guidance radiotherapy	1.34	1.02	NA	0.10	XXX
76965	TC	A	Echo guidance radiotherapy	0.00	0.56	NA	0.00	XXX
76965	26	A	Echo guidance radiotherapy	1.34	0.47	0.47	0.09	XXX

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76970		A	Ultrasound exam follow-up	0.40	2.26	NA	0.05	XXX
76970	TC	A	Ultrasound exam follow-up	0.00	2.11	NA	0.00	XXX
76970	26	A	Ultrasound exam follow-up	0.40	0.15	0.15	0.05	XXX
76975		C	GI endoscopic ultrasound	0.00	NA	NA	0.00	XXX
76975	TC	C	GI endoscopic ultrasound	0.00	NA	NA	0.00	XXX
76975	26	A	GI endoscopic ultrasound	0.81	0.32	0.32	0.07	XXX
76977		A	Us bone density measure	0.05	0.12	NA	0.00	XXX
76977	TC	A	Us bone density measure	0.00	0.10	NA	0.00	XXX
76977	26	A	Us bone density measure	0.05	0.02	0.02	0.00	XXX
76998		C	Us guide, intraop	0.00	NA	NA	0.00	XXX
76998	TC	C	Us guide, intraop	0.00	NA	NA	0.00	XXX
76998	26	A	Us guide, intraop	1.20	0.40	0.40	0.19	XXX
76999		C	Echo examination procedure	0.00	0.00	NA	0.00	XXX
76999	TC	C	Echo examination procedure	0.00	0.00	NA	0.00	XXX
76999	26	C	Echo examination procedure	0.00	0.00	0.00	0.00	XXX
77001		A	Fluoroguide for vein device	0.38	2.62	NA	0.03	ZZZ
77001	TC	A	Fluoroguide for vein device	0.00	2.50	NA	0.00	ZZZ
77001	26	A	Fluoroguide for vein device	0.38	0.12	0.12	0.03	ZZZ
77002		A	Needle localization by xray	0.54	1.38	NA	0.04	XXX
77002	TC	A	Needle localization by xray	0.00	1.18	NA	0.00	XXX
77002	26	A	Needle localization by xray	0.54	0.21	0.21	0.04	XXX
77003		A	Fluoroguide for spine inject	0.60	1.04	NA	0.04	XXX
77003	TC	A	Fluoroguide for spine inject	0.00	0.81	NA	0.00	XXX
77003	26	A	Fluoroguide for spine inject	0.60	0.23	0.23	0.04	XXX
77011		A	Ct scan for localization	1.21	16.85	NA	0.06	XXX
77011	TC	A	Ct scan for localization	0.00	16.41	NA	0.00	XXX
77011	26	A	Ct scan for localization	1.21	0.44	0.44	0.06	XXX
77012		A	Ct scan for needle biopsy	1.16	1.55	NA	0.08	XXX
77012	TC	A	Ct scan for needle biopsy	0.00	1.20	NA	0.00	XXX
77012	26	A	Ct scan for needle biopsy	1.16	0.35	0.35	0.07	XXX
77013		C	Ct guide for tissue ablation	0.00	NA	NA	0.00	XXX
77013	TC	C	Ct guide for tissue ablation	0.00	NA	NA	0.00	XXX
77013	26	A	Ct guide for tissue ablation	3.99	1.19	1.19	0.29	XXX
77014		A	Ct scan for therapy guide	0.85	2.60	NA	0.05	XXX
77014	TC	A	Ct scan for therapy guide	0.00	2.28	NA	0.00	XXX
77014	26	A	Ct scan for therapy guide	0.85	0.32	0.32	0.05	XXX
77021		A	Mr guidance for needle place	1.50	5.25	NA	0.14	XXX
77021	TC	A	Mr guidance for needle place	0.00	4.79	NA	0.00	XXX
77021	26	A	Mr guidance for needle place	1.50	0.47	0.47	0.13	XXX
77022		C	Mri for tissue ablation	0.00	NA	NA	0.00	XXX
77022	TC	C	Mri for tissue ablation	0.00	NA	NA	0.00	XXX
77022	26	A	Mri for tissue ablation	4.24	1.29	1.29	0.31	XXX

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77031		A	Stereotact guide for brst bx	1.59	1.72	NA	0.14	XXX
77031	TC	A	Stereotact guide for brst bx	0.00	1.22	NA	0.00	XXX
77031	26	A	Stereotact guide for brst bx	1.59	0.50	0.50	0.14	XXX
77032		A	Guidance for needle, breast	0.56	0.74	NA	0.04	XXX
77032	TC	A	Guidance for needle, breast	0.00	0.57	NA	0.00	XXX
77032	26	A	Guidance for needle, breast	0.56	0.17	0.17	0.04	XXX
77051		A	Computer dx mammogram add-on	0.06	0.18	0.18	0.00	ZZZ
77051	TC	A	Computer dx mammogram add-on	0.00	0.16	0.16	0.00	ZZZ
77051	26	A	Computer dx mammogram add-on	0.06	0.02	0.02	0.00	ZZZ
77052		A	Comp screen mammogram add-on	0.06	0.18	0.18	0.00	ZZZ
77052	TC	A	Comp screen mammogram add-on	0.00	0.16	0.16	0.00	ZZZ
77052	26	A	Comp screen mammogram add-on	0.06	0.02	0.02	0.00	ZZZ
77053		A	X-ray of mammary duct	0.36	1.09	NA	0.03	XXX
77053	TC	A	X-ray of mammary duct	0.00	0.98	NA	0.00	XXX
77053	26	A	X-ray of mammary duct	0.36	0.11	0.11	0.02	XXX
77054		A	X-ray of mammary ducts	0.45	1.48	NA	0.03	XXX
77054	TC	A	X-ray of mammary ducts	0.00	1.35	NA	0.00	XXX
77054	26	A	X-ray of mammary ducts	0.45	0.14	0.14	0.03	XXX
77055		A	Mammogram, one breast	0.70	1.45	NA	0.05	XXX
77055	TC	A	Mammogram, one breast	0.00	1.24	NA	0.00	XXX
77055	26	A	Mammogram, one breast	0.70	0.21	0.21	0.05	XXX
77056		A	Mammogram, both breasts	0.87	1.89	NA	0.07	XXX
77056	TC	A	Mammogram, both breasts	0.00	1.63	NA	0.00	XXX
77056	26	A	Mammogram, both breasts	0.87	0.27	0.27	0.06	XXX
77057		A	Mammogram, screening	0.70	1.28	NA	0.05	XXX
77057	TC	A	Mammogram, screening	0.00	1.07	NA	0.00	XXX
77057	26	A	Mammogram, screening	0.70	0.22	0.22	0.05	XXX
77058		A	Mri, one breast	1.63	11.95	NA	0.12	XXX
77058	TC	A	Mri, one breast	0.00	11.45	NA	0.00	XXX
77058	26	A	Mri, one breast	1.63	0.50	0.50	0.11	XXX
77059		A	Mri, both breasts	1.63	11.83	NA	0.12	XXX
77059	TC	A	Mri, both breasts	0.00	11.33	NA	0.00	XXX
77059	26	A	Mri, both breasts	1.63	0.50	0.50	0.11	XXX
77071		A	X-ray stress view	0.41	0.87	0.87	0.06	XXX
77072		A	X-rays for bone age	0.19	0.38	NA	0.02	XXX
77072	TC	A	X-rays for bone age	0.00	0.32	NA	0.00	XXX
77072	26	A	X-rays for bone age	0.19	0.06	0.06	0.01	XXX
77073		A	X-rays, bone length studies	0.27	0.70	NA	0.04	XXX
77073	TC	A	X-rays, bone length studies	0.00	0.58	NA	0.00	XXX
77073	26	A	X-rays, bone length studies	0.27	0.11	0.11	0.04	XXX
77074		A	X-rays, bone survey, limited	0.45	1.27	NA	0.03	XXX
77074	TC	A	X-rays, bone survey, limited	0.00	1.13	NA	0.00	XXX
77074	26	A	X-rays, bone survey, limited	0.45	0.14	0.14	0.03	XXX
77075		A	X-rays, bone survey complete	0.54	2.02	NA	0.04	XXX
77075	TC	A	X-rays, bone survey complete	0.00	1.85	NA	0.00	XXX
77075	26	A	X-rays, bone survey complete	0.54	0.17	0.17	0.04	XXX
77076		A	X-rays, bone survey, infant	0.70	1.90	NA	0.05	XXX
77076	TC	A	X-rays, bone survey, infant	0.00	1.69	NA	0.00	XXX
77076	26	A	X-rays, bone survey, infant	0.70	0.21	0.21	0.05	XXX
77077		A	Joint survey, single view	0.31	0.70	NA	0.04	XXX
77077	TC	A	Joint survey, single view	0.00	0.58	NA	0.00	XXX
77077	26	A	Joint survey, single view	0.31	0.12	0.12	0.04	XXX
77078		A	Ct bone density, axial	0.25	2.59	NA	0.02	XXX
77078	TC	A	Ct bone density, axial	0.00	2.51	NA	0.00	XXX
77078	26	A	Ct bone density, axial	0.25	0.08	0.08	0.02	XXX
77079		A	Ct bone density, peripheral	0.22	0.80	NA	0.01	XXX
77079	TC	A	Ct bone density, peripheral	0.00	0.71	NA	0.00	XXX
77079	26	A	Ct bone density, peripheral	0.22	0.08	0.08	0.01	XXX
77080		A	Dxa bone density, axial	0.20	1.04	NA	0.01	XXX
77080	TC	A	Dxa bone density, axial	0.00	0.97	NA	0.00	XXX
77080	26	A	Dxa bone density, axial	0.20	0.07	0.07	0.01	XXX
77081		A	Dxa bone density/peripheral	0.22	0.47	NA	0.01	XXX
77081	TC	A	Dxa bone density/peripheral	0.00	0.39	NA	0.00	XXX
77081	26	A	Dxa bone density/peripheral	0.22	0.08	0.08	0.01	XXX
77082		A	Dxa bone density, vert fx	0.17	0.52	NA	0.01	XXX
77082	TC	A	Dxa bone density, vert fx	0.00	0.45	NA	0.00	XXX
77082	26	A	Dxa bone density, vert fx	0.17	0.06	0.06	0.01	XXX
77083		A	Radiographic absorptiometry	0.20	0.41	NA	0.01	XXX
77083	TC	A	Radiographic absorptiometry	0.00	0.33	NA	0.00	XXX
77083	26	A	Radiographic absorptiometry	0.20	0.07	0.07	0.01	XXX
77084		A	Magnetic image, bone marrow	1.60	8.21	NA	0.12	XXX
77084	TC	A	Magnetic image, bone marrow	0.00	7.70	NA	0.00	XXX
77084	26	A	Magnetic image, bone marrow	1.60	0.50	0.50	0.11	XXX
77261		A	Radiation therapy planning	1.39	0.56	0.56	0.08	XXX
77262		A	Radiation therapy planning	2.11	0.80	0.80	0.13	XXX
77263		A	Radiation therapy planning	3.14	1.19	1.19	0.20	XXX
77280		A	Set radiation therapy field	0.70	3.96	NA	0.04	XXX
77280	TC	A	Set radiation therapy field	0.00	3.69	NA	0.00	XXX
77280	26	A	Set radiation therapy field	0.70	0.27	0.27	0.04	XXX
77285		A	Set radiation therapy field	1.05	7.16	NA	0.07	XXX
77285	TC	A	Set radiation therapy field	0.00	6.77	NA	0.00	XXX
77285	26	A	Set radiation therapy field	1.05	0.40	0.40	0.06	XXX
77290		A	Set radiation therapy field	1.56	11.94	NA	0.10	XXX
77290	TC	A	Set radiation therapy field	0.00	11.35	NA	0.00	XXX
77290	26	A	Set radiation therapy field	1.56	0.59	0.59	0.10	XXX

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[4] Global totals for malpractice RVUs may not sum due to rounding.

CPT[1,3] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
77290	26	A	Set radiation therapy field	1.56	0.59	0.59	0.09	XXX
77295		A	Set radiation therapy field	4.56	6.92	NA	0.29	XXX
77295	TC	A	Set radiation therapy field	0.00	5.19	NA	0.01	XXX
77295	26	A	Set radiation therapy field	4.56	1.73	1.73	0.27	XXX
77299		C	Radiation therapy planning	0.00	0.00	NA	0.00	XXX
77299	TC	C	Radiation therapy planning	0.00	0.00	NA	0.00	XXX
77299	26	C	Radiation therapy planning	0.00	0.00	0.00	0.00	XXX
77300		A	Radiation therapy dose plan	0.62	1.09	NA	0.04	XXX
77300	TC	A	Radiation therapy dose plan	0.00	0.86	NA	0.00	XXX
77300	26	A	Radiation therapy dose plan	0.62	0.24	0.24	0.04	XXX
77301		A	Radiotherapy dose plan, imrt	7.99	51.05	NA	0.50	XXX
77301	TC	A	Radiotherapy dose plan, imrt	0.00	48.03	NA	0.02	XXX
77301	26	A	Radiotherapy dose plan, imrt	7.99	3.02	3.02	0.48	XXX
77305		A	Teletx isodose plan simple	0.70	0.85	NA	0.04	XXX
77305	TC	A	Teletx isodose plan simple	0.00	0.58	NA	0.00	XXX
77305	26	A	Teletx isodose plan simple	0.70	0.26	0.26	0.04	XXX
77310		A	Teletx isodose plan intermed	1.05	1.19	NA	0.07	XXX
77310	TC	A	Teletx isodose plan intermed	0.00	0.79	NA	0.00	XXX
77310	26	A	Teletx isodose plan intermed	1.05	0.40	0.40	0.06	XXX
77315		A	Teletx isodose plan complex	1.56	1.97	NA	0.10	XXX
77315	TC	A	Teletx isodose plan complex	0.00	1.38	NA	0.00	XXX
77315	26	A	Teletx isodose plan complex	1.56	0.59	0.59	0.09	XXX
77321		A	Special teletx port plan	0.95	1.41	NA	0.06	XXX
77321	TC	A	Special teletx port plan	0.00	1.05	NA	0.00	XXX
77321	26	A	Special teletx port plan	0.95	0.36	0.36	0.06	XXX
77326		A	Brachytx isodose calc simp	0.93	2.69	NA	0.06	XXX
77326	TC	A	Brachytx isodose calc simp	0.00	2.34	NA	0.00	XXX
77326	26	A	Brachytx isodose calc simp	0.93	0.35	0.35	0.06	XXX
77327		A	Brachytx isodose calc interm	1.39	3.70	NA	0.09	XXX
77327	TC	A	Brachytx isodose calc interm	0.00	3.18	NA	0.00	XXX
77327	26	A	Brachytx isodose calc interm	1.39	0.53	0.53	0.08	XXX
77328		A	Brachytx isodose plan compl	2.09	4.76	NA	0.13	XXX
77328	TC	A	Brachytx isodose plan compl	0.00	3.96	NA	0.01	XXX
77328	26	A	Brachytx isodose plan compl	2.09	0.79	0.79	0.13	XXX
77331		A	Special radiation dosimetry	0.87	0.78	NA	0.05	XXX
77331	TC	A	Special radiation dosimetry	0.00	0.45	NA	0.00	XXX
77331	26	A	Special radiation dosimetry	0.87	0.33	0.33	0.05	XXX
77332		A	Radiation treatment aid(s)	0.54	1.41	NA	0.03	XXX
77332	TC	A	Radiation treatment aid(s)	0.00	1.20	NA	0.00	XXX
77332	26	A	Radiation treatment aid(s)	0.54	0.21	0.21	0.03	XXX
77333		A	Radiation treatment aid(s)	0.84	0.53	NA	0.05	XXX
77333	TC	A	Radiation treatment aid(s)	0.00	0.21	NA	0.00	XXX
77334		A	Radiation treatment aid(s)	1.24	2.50	NA	0.08	XXX
77334	TC	A	Radiation treatment aid(s)	0.00	2.03	NA	0.00	XXX
77334	26	A	Radiation treatment aid(s)	1.24	0.47	0.47	0.07	XXX
77336		A	Radiation physics consult	0.00	0.99	NA	0.00	XXX
77370		A	Radiation physics consult	0.00	2.64	NA	0.00	XXX
77371		C	Srs, multisource	0.00	0.00	NA	0.00	XXX
77372		A	Srs, linear based	0.00	12.82	NA	0.00	XXX
77373		A	Sbrt delivery	0.00	22.92	NA	0.00	XXX
77399		C	External radiation dosimetry	0.00	0.00	NA	0.00	XXX
77399	TC	C	External radiation dosimetry	0.00	0.00	NA	0.00	XXX
77399	26	C	External radiation dosimetry	0.00	0.00	0.00	0.00	XXX
77401		A	Radiation treatment delivery	0.00	0.42	NA	0.00	XXX
77402		A	Radiation treatment delivery	0.00	3.07	NA	0.00	XXX
77403		A	Radiation treatment delivery	0.00	2.70	NA	0.00	XXX
77404		A	Radiation treatment delivery	0.00	2.92	NA	0.00	XXX
77406		A	Radiation treatment delivery	0.00	2.98	NA	0.00	XXX
77407		A	Radiation treatment delivery	0.00	5.63	NA	0.00	XXX
77408		A	Radiation treatment delivery	0.00	3.71	NA	0.00	XXX
77409		A	Radiation treatment delivery	0.00	3.99	NA	0.00	XXX
77411		A	Radiation treatment delivery	0.00	3.99	NA	0.00	XXX
77412		A	Radiation treatment delivery	0.00	4.88	NA	0.00	XXX
77413		A	Radiation treatment delivery	0.00	4.92	NA	0.00	XXX
77414		A	Radiation treatment delivery	0.00	5.34	NA	0.00	XXX
77416		A	Radiation treatment delivery	0.00	5.37	NA	0.00	XXX
77417		A	Radiology port film(s)	0.00	0.32	NA	0.00	XXX
77418		A	Radiation tx delivery, imrt	0.00	7.98	NA	0.00	XXX
77421		A	Stereoscopic x-ray guidance	0.39	2.13	NA	0.02	XXX
77421	TC	A	Stereoscopic x-ray guidance	0.00	1.98	NA	0.00	XXX
77421	26	A	Stereoscopic x-ray guidance	0.39	0.15	0.15	0.02	XXX
77422		A	Neutron beam tx, simple	0.00	6.28	NA	0.00	XXX
77423		A	Neutron beam tx, complex	0.00	6.55	NA	0.00	XXX
77427		A	Radiation tx management, x5	3.70	1.56	1.56	0.23	XXX
77431		A	Radiation therapy management	1.81	0.85	0.85	0.11	XXX
77432		A	Stereotactic radiation trmt	7.92	3.03	3.03	0.50	XXX
77435		A	Sbrt management	13.00	5.21	NA	0.81	XXX
77470		A	Special radiation treatment	2.09	1.87	NA	0.13	XXX
77470	TC	A	Special radiation treatment	0.00	1.08	NA	0.01	XXX
77470	26	A	Special radiation treatment	2.09	0.79	0.79	0.13	XXX
77499		C	Radiation therapy management	0.00	0.00	NA	0.00	XXX
77499	TC	C	Radiation therapy management	0.00	0.00	NA	0.00	XXX
77499	26	C	Radiation therapy management	0.00	0.00	0.00	0.00	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
77520		C	Proton trmt, simple w/o comp	0.00	0.00	0.00	0.00	XXX
77522		C	Proton trmt, simple w/comp	0.00	0.00	0.00	0.00	XXX
77523		C	Proton trmt, intermediate	0.00	0.00	0.00	0.00	XXX
77525		C	Proton treatment, complex	0.00	0.00	0.00	0.00	XXX
77600		R	Hyperthermia treatment	1.56	9.09	NA	0.10	XXX
77600	TC	R	Hyperthermia treatment	0.00	8.49	NA	0.00	XXX
77600	26	R	Hyperthermia treatment	1.56	0.60	0.60	0.09	XXX
77605		R	Hyperthermia treatment	2.09	26.47	NA	0.34	XXX
77605	TC	R	Hyperthermia treatment	0.00	25.70	NA	0.01	XXX
77605	26	R	Hyperthermia treatment	2.09	0.78	0.78	0.33	XXX
77610		R	Hyperthermia treatment	1.56	14.91	NA	0.09	XXX
77610	TC	R	Hyperthermia treatment	0.00	14.32	NA	0.00	XXX
77610	26	R	Hyperthermia treatment	1.56	0.60	0.60	0.09	XXX
77615		R	Hyperthermia treatment	2.09	23.01	NA	0.13	XXX
77615	TC	R	Hyperthermia treatment	0.00	22.21	NA	0.01	XXX
77615	26	R	Hyperthermia treatment	2.09	0.80	0.80	0.12	XXX
77620		R	Hyperthermia treatment	1.56	12.54	NA	0.07	XXX
77620	TC	R	Hyperthermia treatment	0.00	11.97	NA	0.00	XXX
77620	26	R	Hyperthermia treatment	1.56	0.58	0.58	0.07	XXX
77750		A	Infuse radioactive materials	4.94	4.41	4.41	0.31	090
77750	TC	A	Infuse radioactive materials	0.00	2.54	2.54	0.01	090
77750	26	A	Infuse radioactive materials	4.94	1.87	1.87	0.29	090
77761		A	Apply intrcav radiat simple	3.82	5.84	5.84	0.24	090
77761	TC	A	Apply intrcav radiat simple	0.00	4.43	4.43	0.01	090
77761	26	A	Apply intrcav radiat simple	3.82	1.41	1.41	0.23	090
77762		A	Apply intrcav radiat interm	5.73	7.22	7.22	0.36	090
77762	TC	A	Apply intrcav radiat interm	0.00	5.06	5.06	0.02	090
77762	26	A	Apply intrcav radiat interm	5.73	2.16	2.16	0.34	090
77763		A	Apply intrcav radiat compl	8.60	9.77	9.77	0.54	090
77763	TC	A	Apply intrcav radiat compl	0.00	6.57	6.57	0.02	090
77763	26	A	Apply intrcav radiat compl	8.60	3.20	3.20	0.51	090
77776		A	Apply intersti radiat simpl	4.67	6.39	6.39	0.34	090
77776	TC	A	Apply intersti radiat simpl	0.00	4.74	4.74	0.01	090
77776	26	A	Apply intersti radiat simpl	4.67	1.65	1.65	0.33	090
77777		A	Apply intersti radiat inter	7.49	7.59	7.59	0.54	090
77777	TC	A	Apply intersti radiat inter	0.00	4.87	4.87	0.02	090
77777	26	A	Apply intersti radiat inter	7.49	2.72	2.72	0.52	090
77778		A	Apply intersti radiat compl	11.23	10.84	10.84	0.72	090
77778	TC	A	Apply intersti radiat compl	0.00	6.63	6.63	0.03	090
77778	26	A	Apply intersti radiat compl	11.23	4.21	4.21	0.68	090
77785		A	Hdr brachytx, 1 channel	1.42	3.29	NA	0.09	XXX
77785	TC	A	Hdr brachytx, 1 channel	0.00	2.75	NA	0.00	XXX
77785	26	A	Hdr brachytx, 1 channel	1.42	0.54	0.54	0.09	XXX
77786		A	Hdr brachytx, 2-12 channel	3.25	7.98	NA	0.20	XXX
77786	TC	A	Hdr brachytx, 2-12 channel	0.00	6.74	NA	0.01	XXX
77786	26	A	Hdr brachytx, 2-12 channel	3.25	1.24	1.24	0.19	XXX
77787		A	Hdr brachytx over 12 chan	4.89	14.57	NA	0.31	XXX
77787	TC	A	Hdr brachytx over 12 chan	0.00	12.70	NA	0.01	XXX
77787	26	A	Hdr brachytx over 12 chan	4.89	1.86	1.86	0.29	XXX
77789		A	Apply surface radiation	1.14	1.86	1.86	0.06	000
77789	TC	A	Apply surface radiation	0.00	1.40	1.40	0.00	000
77789	26	A	Apply surface radiation	1.14	0.46	0.46	0.06	000
77790		A	Radiation handling	1.05	1.37	NA	0.06	XXX
77790	TC	A	Radiation handling	0.00	0.98	NA	0.00	XXX
77790	26	A	Radiation handling	1.05	0.39	0.39	0.06	XXX
77799		C	Radium/radioisotope therapy	0.00	0.00	NA	0.00	XXX
77799	TC	C	Radium/radioisotope therapy	0.00	0.00	NA	0.00	XXX
77799	26	C	Radium/radioisotope therapy	0.00	0.00	0.00	0.00	XXX
78000		A	Thyroid, single uptake	0.19	1.53	NA	0.01	XXX
78000	TC	A	Thyroid, single uptake	0.00	1.47	NA	0.00	XXX
78000	26	A	Thyroid, single uptake	0.19	0.05	0.05	0.01	XXX
78001		A	Thyroid, multiple uptakes	0.26	1.96	NA	0.01	XXX
78001	TC	A	Thyroid, multiple uptakes	0.00	1.89	NA	0.00	XXX
78001	26	A	Thyroid, multiple uptakes	0.26	0.08	0.08	0.01	XXX
78003		A	Thyroid suppress/stimul	0.33	1.65	NA	0.01	XXX
78003	TC	A	Thyroid suppress/stimul	0.00	1.55	NA	0.00	XXX
78003	26	A	Thyroid suppress/stimul	0.33	0.10	0.10	0.01	XXX
78006		A	Thyroid imaging with uptake	0.49	5.43	NA	0.03	XXX
78006	TC	A	Thyroid imaging with uptake	0.00	5.29	NA	0.00	XXX
78006	26	A	Thyroid imaging with uptake	0.49	0.14	0.14	0.03	XXX
78007		A	Thyroid image, mult uptakes	0.50	2.58	NA	0.03	XXX
78007	TC	A	Thyroid image, mult uptakes	0.00	2.44	NA	0.00	XXX
78007	26	A	Thyroid image, mult uptakes	0.50	0.15	0.15	0.03	XXX
78010		A	Thyroid imaging	0.39	3.66	NA	0.02	XXX
78010	TC	A	Thyroid imaging	0.00	3.55	NA	0.00	XXX
78010	26	A	Thyroid imaging	0.39	0.11	0.11	0.02	XXX
78011		A	Thyroid imaging with flow	0.45	3.90	NA	0.03	XXX
78011	TC	A	Thyroid imaging with flow	0.00	3.77	NA	0.00	XXX
78011	26	A	Thyroid imaging with flow	0.45	0.13	0.13	0.03	XXX
78015		A	Thyroid met imaging	0.67	4.57	NA	0.05	XXX
78015	TC	A	Thyroid met imaging	0.00	4.40	NA	0.00	XXX
78015	26	A	Thyroid met imaging	0.67	0.17	0.17	0.05	XXX
78016		A	Thyroid met imaging/studies	0.82	6.08	NA	0.04	XXX
78016	TC	A	Thyroid met imaging/studies	0.00	5.97	NA	0.00	XXX

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CPT[1,2] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
78016	26	A	Thyroid met imaging/studies	0.82	0.11	0.11	0.03	XXX
78018		A	Thyroid met imaging, body	0.86	6.77	NA	0.05	XXX
78018	TC	A	Thyroid met imaging, body	0.00	6.55	NA	0.00	XXX
78018	26	A	Thyroid met imaging, body	0.86	0.22	0.22	0.05	XXX
78020		A	Thyroid met uptake	0.60	1.42	1.42	0.03	ZZZ
78020	TC	A	Thyroid met uptake	0.00	1.28	1.28	0.00	ZZZ
78020	26	A	Thyroid met uptake	0.60	0.14	0.14	0.03	ZZZ
78070		A	Parathyroid nuclear imaging	0.82	2.92	NA	0.05	XXX
78070	TC	A	Parathyroid nuclear imaging	0.00	2.69	NA	0.00	XXX
78070	26	A	Parathyroid nuclear imaging	0.82	0.23	0.23	0.05	XXX
78075		A	Adrenal nuclear imaging	0.74	9.64	NA	0.05	XXX
78075	TC	A	Adrenal nuclear imaging	0.00	9.45	NA	0.00	XXX
78075	26	A	Adrenal nuclear imaging	0.74	0.18	0.18	0.05	XXX
78099		C	Endocrine nuclear procedure	0.00	0.00	NA	0.00	XXX
78099	TC	C	Endocrine nuclear procedure	0.00	0.00	NA	0.00	XXX
78099	26	C	Endocrine nuclear procedure	0.00	0.00	0.00	0.00	XXX
78102		A	Bone marrow imaging, ltd	0.55	3.49	NA	0.03	XXX
78102	TC	A	Bone marrow imaging, ltd	0.00	3.36	NA	0.00	XXX
78102	26	A	Bone marrow imaging, ltd	0.55	0.14	0.14	0.03	XXX
78103		A	Bone marrow imaging, mult	0.75	4.59	NA	0.05	XXX
78103	TC	A	Bone marrow imaging, mult	0.00	4.39	NA	0.00	XXX
78103	26	A	Bone marrow imaging, mult	0.75	0.19	0.19	0.05	XXX
78104		A	Bone marrow imaging, body	0.80	5.22	NA	0.06	XXX
78104	TC	A	Bone marrow imaging, body	0.00	5.00	NA	0.00	XXX
78104	26	A	Bone marrow imaging, body	0.80	0.21	0.21	0.06	XXX
78110		A	Plasma volume, single	0.19	1.88	NA	0.01	XXX
78110	TC	A	Plasma volume, single	0.00	1.82	NA	0.00	XXX
78110	26	A	Plasma volume, single	0.19	0.06	0.06	0.01	XXX
78111		A	Plasma volume, multiple	0.22	1.53	NA	0.01	XXX
78111	TC	A	Plasma volume, multiple	0.00	1.50	NA	0.00	XXX
78111	26	A	Plasma volume, multiple	0.22	0.04	0.04	0.01	XXX
78120		A	Red cell mass, single	0.23	1.70	NA	0.01	XXX
78120	TC	A	Red cell mass, single	0.00	1.64	NA	0.00	XXX
78120	26	A	Red cell mass, single	0.23	0.06	0.06	0.01	XXX
78121		A	Red cell mass, multiple	0.32	1.42	NA	0.01	XXX
78121	TC	A	Red cell mass, multiple	0.00	1.38	NA	0.00	XXX
78121	26	A	Red cell mass, multiple	0.32	0.04	0.04	0.01	XXX
78122		A	Blood volume	0.45	1.74	NA	0.02	XXX
78122	TC	A	Blood volume	0.00	1.64	NA	0.00	XXX
78122	26	A	Blood volume	0.45	0.10	0.10	0.02	XXX
78130		A	Red cell survival study	0.61	3.06	NA	0.04	XXX
78130	TC	A	Red cell survival study	0.00	2.87	NA	0.00	XXX
78135		A	Red cell survival kinetics	0.64	7.88	NA	0.05	XXX
78135	TC	A	Red cell survival kinetics	0.00	7.68	NA	0.00	XXX
78135	26	A	Red cell survival kinetics	0.64	0.20	0.20	0.04	XXX
78140		A	Red cell sequestration	0.61	2.47	NA	0.04	XXX
78140	TC	A	Red cell sequestration	0.00	2.29	NA	0.00	XXX
78140	26	A	Red cell sequestration	0.61	0.18	0.18	0.04	XXX
78185		A	Spleen imaging	0.40	4.57	NA	0.02	XXX
78185	TC	A	Spleen imaging	0.00	4.46	NA	0.00	XXX
78185	26	A	Spleen imaging	0.40	0.11	0.11	0.02	XXX
78190		A	Platelet survival, kinetics	1.09	9.17	NA	0.06	XXX
78190	TC	A	Platelet survival, kinetics	0.00	8.78	NA	0.00	XXX
78190	26	A	Platelet survival, kinetics	1.09	0.40	0.40	0.06	XXX
78191		A	Platelet survival	0.61	3.04	NA	0.04	XXX
78191	TC	A	Platelet survival	0.00	2.85	NA	0.00	XXX
78191	26	A	Platelet survival	0.61	0.19	0.19	0.04	XXX
78195		A	Lymph system imaging	1.20	7.60	NA	0.09	XXX
78195	TC	A	Lymph system imaging	0.00	7.26	NA	0.00	XXX
78195	26	A	Lymph system imaging	1.20	0.33	0.33	0.09	XXX
78199		C	Blood/lymph nuclear exam	0.00	0.00	NA	0.00	XXX
78199	TC	C	Blood/lymph nuclear exam	0.00	0.00	NA	0.00	XXX
78199	26	C	Blood/lymph nuclear exam	0.00	0.00	0.00	0.00	XXX
78201		A	Liver imaging	0.44	4.29	NA	0.04	XXX
78201	TC	A	Liver imaging	0.00	4.17	NA	0.00	XXX
78201	26	A	Liver imaging	0.44	0.12	0.12	0.04	XXX
78202		A	Liver imaging with flow	0.51	4.36	NA	0.02	XXX
78202	TC	A	Liver imaging with flow	0.00	4.24	NA	0.00	XXX
78202	26	A	Liver imaging with flow	0.51	0.12	0.12	0.02	XXX
78205		A	Liver imaging (3D)	0.71	4.50	NA	0.05	XXX
78205	TC	A	Liver imaging (3D)	0.00	4.31	NA	0.00	XXX
78205	26	A	Liver imaging (3D)	0.71	0.19	0.19	0.05	XXX
78206		A	Liver image (3d) with flow	0.96	7.63	NA	0.06	XXX
78206	TC	A	Liver image (3d) with flow	0.00	7.35	NA	0.00	XXX
78206	26	A	Liver image (3d) with flow	0.96	0.28	0.28	0.06	XXX
78215		A	Liver and spleen imaging	0.49	4.18	NA	0.03	XXX
78215	TC	A	Liver and spleen imaging	0.00	4.04	NA	0.00	XXX
78215	26	A	Liver and spleen imaging	0.49	0.14	0.14	0.03	XXX
78216		A	Liver & spleen image/flow	0.57	2.38	NA	0.03	XXX
78216	TC	A	Liver & spleen image/flow	0.00	2.22	NA	0.00	XXX
78216	26	A	Liver & spleen image/flow	0.57	0.16	0.16	0.03	XXX
78220		A	Liver function study	0.49	2.58	NA	0.03	XXX
78220	TC	A	Liver function study	0.00	2.44	NA	0.00	XXX

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CPT[1,3] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
78220	26	A	Liver function study	0.49	0.14	0.14	0.03	XXX
78223		A	Hepatobiliary imaging	0.84	7.48	NA	0.06	XXX
78223	TC	A	Hepatobiliary imaging	0.00	7.23	NA	0.00	XXX
78223	26	A	Hepatobiliary imaging	0.84	0.24	0.24	0.05	XXX
78230		A	Salivary gland imaging	0.45	3.67	NA	0.03	XXX
78230	TC	A	Salivary gland imaging	0.00	3.53	NA	0.00	XXX
78230	26	A	Salivary gland imaging	0.45	0.14	0.14	0.03	XXX
78231		A	Serial salivary imaging	0.52	2.44	NA	0.02	XXX
78231	TC	A	Serial salivary imaging	0.00	2.28	NA	0.00	XXX
78231	26	A	Serial salivary imaging	0.52	0.16	0.16	0.02	XXX
78232		A	Salivary gland function exam	0.47	1.84	NA	0.03	XXX
78232	TC	A	Salivary gland function exam	0.00	1.77	NA	0.00	XXX
78232	26	A	Salivary gland function exam	0.47	0.06	0.06	0.03	XXX
78258		A	Esophageal motility study	0.74	5.22	NA	0.04	XXX
78258	TC	A	Esophageal motility study	0.00	4.97	NA	0.00	XXX
78258	26	A	Esophageal motility study	0.74	0.24	0.24	0.04	XXX
78261		A	Gastric mucosa imaging	0.69	5.40	NA	0.03	XXX
78261	TC	A	Gastric mucosa imaging	0.00	5.19	NA	0.00	XXX
78261	26	A	Gastric mucosa imaging	0.69	0.21	0.21	0.03	XXX
78262		A	Gastroesophageal reflux exam	0.68	5.33	NA	0.03	XXX
78262	TC	A	Gastroesophageal reflux exam	0.00	5.13	NA	0.00	XXX
78262	26	A	Gastroesophageal reflux exam	0.68	0.19	0.19	0.03	XXX
78264		A	Gastric emptying study	0.78	6.23	NA	0.05	XXX
78264	TC	A	Gastric emptying study	0.00	6.01	NA	0.00	XXX
78264	26	A	Gastric emptying study	0.78	0.22	0.22	0.05	XXX
78270		A	Vit B-12 absorption exam	0.20	1.73	NA	0.01	XXX
78270	TC	A	Vit B-12 absorption exam	0.00	1.67	NA	0.00	XXX
78270	26	A	Vit B-12 absorption exam	0.20	0.06	0.06	0.01	XXX
78271		A	Vit b-12 absrp exam, int fac	0.20	2.03	NA	0.01	XXX
78271	TC	A	Vit b-12 absrp exam, int fac	0.00	1.96	NA	0.00	XXX
78271	26	A	Vit b-12 absrp exam, int fac	0.20	0.07	0.07	0.01	XXX
78272		A	Vit B-12 absorp, combined	0.27	1.88	NA	0.01	XXX
78272	TC	A	Vit B-12 absorp, combined	0.00	1.79	NA	0.00	XXX
78272	26	A	Vit B-12 absorp, combined	0.27	0.08	0.08	0.01	XXX
78278		A	Acute GI blood loss imaging	0.99	7.51	NA	0.07	XXX
78278	TC	A	Acute GI blood loss imaging	0.00	7.23	NA	0.00	XXX
78278	26	A	Acute GI blood loss imaging	0.99	0.28	0.28	0.07	XXX
78282		C	GI protein loss exam	0.00	0.00	NA	0.00	XXX
78282	TC	C	GI protein loss exam	0.00	0.00	NA	0.00	XXX
78282	26	A	GI protein loss exam	0.38	0.12	0.12	0.03	XXX
78290		A	Meckel√Es divert exam	0.68	7.44	NA	0.05	XXX
78290	TC	A	Meckel√Es divert exam	0.00	7.24	NA	0.00	XXX
78291		A	Leveen/shunt patency exam	0.88	5.38	NA	0.06	XXX
78291	TC	A	Leveen/shunt patency exam	0.00	5.14	NA	0.00	XXX
78291	26	A	Leveen/shunt patency exam	0.88	0.24	0.24	0.06	XXX
78299		C	GI nuclear procedure	0.00	0.00	NA	0.00	XXX
78299	TC	C	GI nuclear procedure	0.00	0.00	NA	0.00	XXX
78299	26	C	GI nuclear procedure	0.00	0.00	0.00	0.00	XXX
78300		A	Bone imaging, limited area	0.62	3.73	NA	0.04	XXX
78300	TC	A	Bone imaging, limited area	0.00	3.34	NA	0.00	XXX
78300	26	A	Bone imaging, limited area	0.62	0.19	0.19	0.04	XXX
78305		A	Bone imaging, multiple areas	0.83	4.86	NA	0.05	XXX
78305	TC	A	Bone imaging, multiple areas	0.00	4.62	NA	0.00	XXX
78305	26	A	Bone imaging, multiple areas	0.83	0.24	0.24	0.05	XXX
78306		A	Bone imaging, whole body	0.86	5.26	NA	0.06	XXX
78306	TC	A	Bone imaging, whole body	0.00	5.02	NA	0.00	XXX
78306	26	A	Bone imaging, whole body	0.86	0.25	0.25	0.06	XXX
78315		A	Bone imaging, 3 phase	1.02	7.48	NA	0.07	XXX
78315	TC	A	Bone imaging, 3 phase	0.00	7.20	NA	0.00	XXX
78315	26	A	Bone imaging, 3 phase	1.02	0.29	0.29	0.07	XXX
78320		A	Bone imaging (3D)	1.04	4.56	NA	0.07	XXX
78320	TC	A	Bone imaging (3D)	0.00	4.28	NA	0.00	XXX
78320	26	A	Bone imaging (3D)	1.04	0.28	0.28	0.06	XXX
78350		N	Bone mineral, single photon	0.22	0.58	NA	0.01	XXX
78350	TC	N	Bone mineral, single photon	0.00	0.50	NA	0.00	XXX
78350	26	N	Bone mineral, single photon	0.22	0.08	0.08	0.01	XXX
78351		N	Bone mineral, dual photon	0.30	NA	0.11	0.02	XXX
78399		C	Musculoskeletal nuclear exam	0.00	0.00	NA	0.00	XXX
78399	TC	C	Musculoskeletal nuclear exam	0.00	0.00	NA	0.00	XXX
78399	26	C	Musculoskeletal nuclear exam	0.00	0.00	0.00	0.00	XXX
78414		C	Non-imaging heart function	0.00	0.00	NA	0.00	XXX
78414	TC	C	Non-imaging heart function	0.00	0.00	NA	0.00	XXX
78414	26	A	Non-imaging heart function	0.45	0.17	0.17	0.02	XXX
78428		A	Cardiac shunt imaging	0.78	4.01	NA	0.04	XXX
78428	TC	A	Cardiac shunt imaging	0.00	3.81	NA	0.00	XXX
78428	26	A	Cardiac shunt imaging	0.78	0.21	0.21	0.04	XXX
78445		A	Vascular flow imaging	0.49	3.71	NA	0.03	XXX
78445	TC	A	Vascular flow imaging	0.00	3.59	NA	0.00	XXX
78445	26	A	Vascular flow imaging	0.49	0.13	0.13	0.03	XXX
78456		A	Acute venous thrombus image	1.00	7.26	NA	0.05	XXX
78456	TC	A	Acute venous thrombus image	0.00	6.93	NA	0.00	XXX
78456	26	A	Acute venous thrombus image	1.00	0.34	0.34	0.05	XXX
78457		A	Venous thrombosis imaging	0.77	4.08	NA	0.05	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
78457	TC	A	Venous thrombosis imaging	0.00	3.85	NA	0.00	XXX
78457	26	A	Venous thrombosis imaging	0.77	0.23	0.23	0.05	XXX
78458		A	Ven thrombosis images, bilat	0.90	3.63	NA	0.04	XXX
78458	TC	A	Ven thrombosis images, bilat	0.00	3.43	NA	0.00	XXX
78458	26	A	Ven thrombosis images, bilat	0.90	0.20	0.20	0.04	XXX
78459		C	Heart muscle imaging (PET)	0.00	0.00	NA	0.00	XXX
78459	TC	C	Heart muscle imaging (PET)	0.00	0.00	NA	0.00	XXX
78459	26	A	Heart muscle imaging (PET)	1.50	0.37	0.37	0.08	XXX
78460		A	Heart muscle blood, single	0.86	4.01	NA	0.06	XXX
78460	TC	A	Heart muscle blood, single	0.00	3.74	NA	0.00	XXX
78460	26	A	Heart muscle blood, single	0.86	0.27	0.27	0.06	XXX
78461		A	Heart muscle blood, multiple	1.23	3.38	NA	0.07	XXX
78461	TC	A	Heart muscle blood, multiple	0.00	3.00	NA	0.00	XXX
78461	26	A	Heart muscle blood, multiple	1.23	0.37	0.37	0.07	XXX
78464		A	Heart image (3d), single	1.09	4.39	NA	0.06	XXX
78464	TC	A	Heart image (3d), single	0.00	4.05	NA	0.00	XXX
78464	26	A	Heart image (3d), single	1.09	0.34	0.34	0.05	XXX
78465		A	Heart image (3d), multiple	1.46	8.54	NA	0.08	XXX
78465	TC	A	Heart image (3d), multiple	0.00	8.06	NA	0.00	XXX
78465	26	A	Heart image (3d), multiple	1.46	0.48	0.48	0.07	XXX
78466		A	Heart infarct image	0.69	3.61	NA	0.04	XXX
78466	TC	A	Heart infarct image	0.00	3.40	NA	0.00	XXX
78466	26	A	Heart infarct image	0.69	0.22	0.22	0.03	XXX
78468		A	Heart infarct image (ef)	0.80	4.29	NA	0.04	XXX
78468	TC	A	Heart infarct image (ef)	0.00	4.03	NA	0.00	XXX
78468	26	A	Heart infarct image (ef)	0.80	0.26	0.26	0.04	XXX
78469		A	Heart infarct image (3D)	0.92	5.06	NA	0.04	XXX
78469	TC	A	Heart infarct image (3D)	0.00	4.75	NA	0.00	XXX
78469	26	A	Heart infarct image (3D)	0.92	0.31	0.31	0.04	XXX
78472		A	Gated heart, planar, single	0.98	4.80	NA	0.05	XXX
78472	TC	A	Gated heart, planar, single	0.00	4.51	NA	0.00	XXX
78472	26	A	Gated heart, planar, single	0.98	0.29	0.29	0.05	XXX
78473		A	Gated heart, multiple	1.47	6.02	NA	0.08	XXX
78473	TC	A	Gated heart, multiple	0.00	5.56	NA	0.00	XXX
78473	26	A	Gated heart, multiple	1.47	0.46	0.46	0.07	XXX
78478		A	Heart wall motion add-on	0.50	0.56	NA	0.03	XXX
78478	TC	A	Heart wall motion add-on	0.00	0.40	NA	0.00	XXX
78478	26	A	Heart wall motion add-on	0.50	0.16	0.16	0.02	XXX
78480		A	Heart function add-on	0.30	0.49	NA	0.02	XXX
78480	TC	A	Heart function add-on	0.00	0.40	NA	0.00	XXX
78480	26	A	Heart function add-on	0.30	0.10	0.10	0.01	XXX
78481		A	Heart first pass, single	0.98	3.68	NA	0.05	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
78481	TC	A	Heart first pass, single	0.00	3.35	NA	0.00	XXX
78481	26	A	Heart first pass, single	0.98	0.33	0.33	0.05	XXX
78483		A	Heart first pass, multiple	1.47	4.86	NA	0.08	XXX
78483	TC	A	Heart first pass, multiple	0.00	4.37	NA	0.00	XXX
78483	26	A	Heart first pass, multiple	1.47	0.49	0.49	0.07	XXX
78491		C	Heart image (pet), single	0.00	0.00	NA	0.00	XXX
78491	TC	C	Heart image (pet), single	0.00	0.00	NA	0.00	XXX
78491	26	A	Heart image (pet), single	1.50	0.42	0.42	0.08	XXX
78492		C	Heart image (pet), multiple	0.00	0.00	NA	0.00	XXX
78492	TC	C	Heart image (pet), multiple	0.00	0.00	NA	0.00	XXX
78492	26	A	Heart image (pet), multiple	1.87	0.55	0.55	0.10	XXX
78494		A	Heart image, spect	1.19	4.84	NA	0.06	XXX
78494	TC	A	Heart image, spect	0.00	4.44	NA	0.00	XXX
78494	26	A	Heart image, spect	1.19	0.40	0.40	0.06	XXX
78496		A	Heart first pass add-on	0.50	0.64	0.64	0.03	ZZZ
78496	TC	A	Heart first pass add-on	0.00	0.48	0.48	0.00	ZZZ
78496	26	A	Heart first pass add-on	0.50	0.16	0.16	0.02	ZZZ
78499		C	Cardiovascular nuclear exam	0.00	0.00	NA	0.00	XXX
78499	TC	C	Cardiovascular nuclear exam	0.00	0.00	NA	0.00	XXX
78499	26	C	Cardiovascular nuclear exam	0.00	0.00	0.00	0.00	XXX
78580		A	Lung perfusion imaging	0.74	4.37	NA	0.04	XXX
78580	TC	A	Lung perfusion imaging	0.00	4.16	NA	0.00	XXX
78580	26	A	Lung perfusion imaging	0.74	0.21	0.21	0.04	XXX
78584		A	Lung V/Q image single breath	0.99	2.58	NA	0.07	XXX
78584	TC	A	Lung V/Q image single breath	0.00	2.28	NA	0.00	XXX
78584	26	A	Lung V/Q image single breath	0.99	0.30	0.30	0.06	XXX
78585		A	Lung V/Q imaging	1.09	7.51	NA	0.07	XXX
78585	TC	A	Lung V/Q imaging	0.00	7.20	NA	0.00	XXX
78585	26	A	Lung V/Q imaging	1.09	0.31	0.31	0.06	XXX
78586		A	Aerosol lung image, single	0.40	3.67	NA	0.02	XXX
78586	TC	A	Aerosol lung image, single	0.00	3.55	NA	0.00	XXX
78586	26	A	Aerosol lung image, single	0.40	0.12	0.12	0.02	XXX
78587		A	Aerosol lung image, multiple	0.49	4.61	NA	0.03	XXX
78587	TC	A	Aerosol lung image, multiple	0.00	4.48	NA	0.00	XXX
78587	26	A	Aerosol lung image, multiple	0.49	0.13	0.13	0.03	XXX
78588		A	Perfusion lung image	1.09	7.58	NA	0.07	XXX
78588	TC	A	Perfusion lung image	0.00	7.27	NA	0.00	XXX
78588	26	A	Perfusion lung image	1.09	0.31	0.31	0.07	XXX
78591		A	Vent image, 1 breath, 1 proj	0.40	3.67	NA	0.02	XXX
78591	TC	A	Vent image, 1 breath, 1 proj	0.00	3.55	NA	0.00	XXX
78591	26	A	Vent image, 1 breath, 1 proj	0.40	0.12	0.12	0.02	XXX
78593		A	Vent image, 1 proj, gas	0.49	4.19	NA	0.04	XXX

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78593	TC	A	Vent image, 1 proj, gas	0.00	4.06	NA	0.00	XXX
78593	26	A	Vent image, 1 proj, gas	0.49	0.14	0.14	0.03	XXX
78594		A	Vent image, mult proj, gas	0.53	4.45	NA	0.02	XXX
78594	TC	A	Vent image, mult proj, gas	0.00	4.31	NA	0.00	XXX
78594	26	A	Vent image, mult proj, gas	0.53	0.13	0.13	0.02	XXX
78596		A	Lung differential function	1.27	7.70	NA	0.07	XXX
78596	TC	A	Lung differential function	0.00	7.35	NA	0.00	XXX
78596	26	A	Lung differential function	1.27	0.35	0.35	0.06	XXX
78599		C	Respiratory nuclear exam	0.00	0.00	NA	0.00	XXX
78599	TC	C	Respiratory nuclear exam	0.00	0.00	NA	0.00	XXX
78599	26	C	Respiratory nuclear exam	0.00	0.00	0.00	0.00	XXX
78600		A	Brain image < 4 views	0.44	3.94	NA	0.02	XXX
78600	TC	A	Brain image < 4 views	0.00	3.81	NA	0.00	XXX
78600	26	A	Brain image < 4 views	0.44	0.13	0.13	0.02	XXX
78601		A	Brain image w/flow < 4 views	0.51	4.62	NA	0.03	XXX
78601	TC	A	Brain image w/flow < 4 views	0.00	4.48	NA	0.00	XXX
78601	26	A	Brain image w/flow < 4 views	0.51	0.14	0.14	0.03	XXX
78605		A	Brain image 4+ views	0.53	4.20	NA	0.04	XXX
78605	TC	A	Brain image 4+ views	0.00	4.05	NA	0.00	XXX
78605	26	A	Brain image 4+ views	0.53	0.15	0.15	0.04	XXX
78606		A	Brain image w/flow 4 + views	0.64	7.69	NA	0.03	XXX
78606	TC	A	Brain image w/flow 4 + views	0.00	7.50	NA	0.00	XXX
78606	26	A	Brain image w/flow 4 + views	0.64	0.19	0.19	0.03	XXX
78607		A	Brain imaging (3D)	1.23	7.38	NA	0.07	XXX
78607	TC	A	Brain imaging (3D)	0.00	7.07	NA	0.00	XXX
78607	26	A	Brain imaging (3D)	1.23	0.31	0.31	0.07	XXX
78608		C	Brain imaging (PET)	0.00	0.00	NA	0.00	XXX
78608	TC	C	Brain imaging (PET)	0.00	0.00	NA	0.00	XXX
78608	26	A	Brain imaging (PET)	1.50	0.39	0.39	0.09	XXX
78609		N	Brain imaging (PET)	1.50	0.55	NA	0.08	XXX
78609	26	N	Brain imaging (PET)	1.50	0.55	0.55	0.08	XXX
78610		A	Brain flow imaging only	0.30	3.77	NA	0.01	XXX
78610	TC	A	Brain flow imaging only	0.00	3.68	NA	0.00	XXX
78610	26	A	Brain flow imaging only	0.30	0.08	0.08	0.01	XXX
78630		A	Cerebrospinal fluid scan	0.68	7.59	NA	0.04	XXX
78630	TC	A	Cerebrospinal fluid scan	0.00	7.40	NA	0.00	XXX
78630	26	A	Cerebrospinal fluid scan	0.68	0.19	0.19	0.04	XXX
78635		A	CSF ventriculography	0.61	7.61	NA	0.03	XXX
78635	TC	A	CSF ventriculography	0.00	7.42	NA	0.00	XXX
78635	26	A	CSF ventriculography	0.61	0.19	0.19	0.03	XXX
78645		A	CSF shunt evaluation	0.57	7.28	NA	0.04	XXX
78645	TC	A	CSF shunt evaluation	0.00	7.13	NA	0.00	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
78645	26	A	CSF shunt evaluation	0.57	0.15	0.15	0.04	XXX
78647		A	Cerebrospinal fluid scan	0.90	5.91	NA	0.07	XXX
78647	TC	A	Cerebrospinal fluid scan	0.00	5.79	NA	0.00	XXX
78647	26	A	Cerebrospinal fluid scan	0.90	0.11	0.11	0.06	XXX
78650		A	CSF leakage imaging	0.61	7.34	NA	0.04	XXX
78650	TC	A	CSF leakage imaging	0.00	7.19	NA	0.00	XXX
78650	26	A	CSF leakage imaging	0.61	0.16	0.16	0.04	XXX
78660		A	Nuclear exam of tear flow	0.53	3.84	NA	0.02	XXX
78660	TC	A	Nuclear exam of tear flow	0.00	3.67	NA	0.00	XXX
78660	26	A	Nuclear exam of tear flow	0.53	0.17	0.17	0.01	XXX
78699		C	Nervous system nuclear exam	0.00	0.00	NA	0.00	XXX
78699	TC	C	Nervous system nuclear exam	0.00	0.00	NA	0.00	XXX
78699	26	C	Nervous system nuclear exam	0.00	0.00	0.00	0.00	XXX
78700		A	Kidney imaging, morphol	0.45	3.70	NA	0.03	XXX
78700	TC	A	Kidney imaging, morphol	0.00	3.57	NA	0.00	XXX
78700	26	A	Kidney imaging, morphol	0.45	0.13	0.13	0.03	XXX
78701		A	Kidney imaging with flow	0.49	4.70	NA	0.03	XXX
78701	TC	A	Kidney imaging with flow	0.00	4.56	NA	0.00	XXX
78701	26	A	Kidney imaging with flow	0.49	0.14	0.14	0.03	XXX
78707		A	K flow/funct image w/o drug	0.96	4.70	NA	0.06	XXX
78707	TC	A	K flow/funct image w/o drug	0.00	4.44	NA	0.00	XXX
78707	26	A	K flow/funct image w/o drug	0.96	0.26	0.26	0.06	XXX
78708		A	K flow/funct image w/drug	1.21	2.87	NA	0.08	XXX
78708	TC	A	K flow/funct image w/drug	0.00	2.53	NA	0.00	XXX
78708	26	A	K flow/funct image w/drug	1.21	0.33	0.33	0.08	XXX
78709		A	K flow/funct image, multiple	1.41	7.67	NA	0.09	XXX
78709	TC	A	K flow/funct image, multiple	0.00	7.28	NA	0.00	XXX
78709	26	A	K flow/funct image, multiple	1.41	0.39	0.39	0.08	XXX
78710		A	Kidney imaging (3D)	0.66	4.20	NA	0.03	XXX
78710	TC	A	Kidney imaging (3D)	0.00	4.05	NA	0.00	XXX
78710	26	A	Kidney imaging (3D)	0.66	0.15	0.15	0.03	XXX
78725		A	Kidney function study	0.38	2.18	NA	0.02	XXX
78725	TC	A	Kidney function study	0.00	2.06	NA	0.00	XXX
78725	26	A	Kidney function study	0.38	0.12	0.12	0.02	XXX
78730		A	Urinary bladder retention	0.15	1.51	NA	0.01	ZZZ
78730	TC	A	Urinary bladder retention	0.00	1.46	NA	0.00	ZZZ
78730	26	A	Urinary bladder retention	0.15	0.05	0.05	0.01	ZZZ
78740		A	Ureteral reflux study	0.57	4.98	NA	0.04	XXX
78740	TC	A	Ureteral reflux study	0.00	4.80	NA	0.00	XXX
78740	26	A	Ureteral reflux study	0.57	0.18	0.18	0.03	XXX
78761		A	Testicular imaging w/flow	0.71	4.44	NA	0.05	XXX
78761	TC	A	Testicular imaging w/flow	0.00	4.22	NA	0.00	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
78761	26	A	Testicular imaging w/flow	0.71	0.22	0.22	0.05	XXX
78799		C	Genitourinary nuclear exam	0.00	0.00	NA	0.00	XXX
78799	TC	C	Genitourinary nuclear exam	0.00	0.00	NA	0.00	XXX
78799	26	C	Genitourinary nuclear exam	0.00	0.00	0.00	0.00	XXX
78800		A	Tumor imaging, limited area	0.66	3.99	NA	0.04	XXX
78800	TC	A	Tumor imaging, limited area	0.00	3.78	NA	0.00	XXX
78800	26	A	Tumor imaging, limited area	0.66	0.20	0.20	0.04	XXX
78801		A	Tumor imaging, mult areas	0.79	5.31	NA	0.05	XXX
78801	TC	A	Tumor imaging, mult areas	0.00	5.08	NA	0.00	XXX
78801	26	A	Tumor imaging, mult areas	0.79	0.23	0.23	0.05	XXX
78802		A	Tumor imaging, whole body	0.86	6.94	NA	0.06	XXX
78802	TC	A	Tumor imaging, whole body	0.00	6.71	NA	0.00	XXX
78802	26	A	Tumor imaging, whole body	0.86	0.23	0.23	0.05	XXX
78803		A	Tumor imaging (3D)	1.09	7.20	NA	0.07	XXX
78803	TC	A	Tumor imaging (3D)	0.00	6.92	NA	0.00	XXX
78803	26	A	Tumor imaging (3D)	1.09	0.27	0.27	0.06	XXX
78804		A	Tumor imaging, whole body	1.07	12.81	NA	0.07	XXX
78804	TC	A	Tumor imaging, whole body	0.00	12.52	NA	0.00	XXX
78804	26	A	Tumor imaging, whole body	1.07	0.29	0.29	0.06	XXX
78805		A	Abscess imaging, ltd area	0.73	3.65	NA	0.05	XXX
78805	TC	A	Abscess imaging, ltd area	0.00	3.45	NA	0.00	XXX
78805	26	A	Abscess imaging, ltd area	0.73	0.20	0.20	0.04	XXX
78806		A	Abscess imaging, whole body	0.86	7.19	NA	0.05	XXX
78806	TC	A	Abscess imaging, whole body	0.00	6.96	NA	0.00	XXX
78806	26	A	Abscess imaging, whole body	0.86	0.23	0.23	0.05	XXX
78807		A	Nuclear localization/abscess	1.09	7.11	NA	0.07	XXX
78807	TC	A	Nuclear localization/abscess	0.00	6.85	NA	0.00	XXX
78807	26	A	Nuclear localization/abscess	1.09	0.26	0.26	0.06	XXX
78808		A	Iv inj ra drug dx study	0.18	0.84	NA	0.01	XXX
78811		C	Pet image, ltd area	0.00	0.00	NA	0.00	XXX
78811	TC	C	Pet image, ltd area	0.00	0.00	NA	0.00	XXX
78811	26	A	Pet image, ltd area	1.54	0.45	0.45	0.14	XXX
78812		C	Pet image, skull-thigh	0.00	0.00	NA	0.00	XXX
78812	TC	C	Pet image, skull-thigh	0.00	0.00	NA	0.00	XXX
78812	26	A	Pet image, skull-thigh	1.93	0.54	0.54	0.13	XXX
78813		C	Pet image, full body	0.00	0.00	NA	0.00	XXX
78813	TC	C	Pet image, full body	0.00	0.00	NA	0.00	XXX
78813	26	A	Pet image, full body	2.00	0.55	0.55	0.14	XXX
78814		C	Pet image w/ct, lmtd	0.00	0.00	NA	0.00	XXX
78814	TC	C	Pet image w/ct, lmtd	0.00	0.00	NA	0.00	XXX
78814	26	A	Pet image w/ct, lmtd	2.20	0.61	0.61	0.15	XXX
78815		C	Pet image w/ct, skull-thigh	0.00	0.00	NA	0.00	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
78815	TC	C	Pet image w/ct, skull-thigh	0.00	0.00	NA	0.00	XXX
78815	26	A	Pet image w/ct, skull-thigh	2.44	0.68	0.68	0.17	XXX
78816		C	Pet image w/ct, full body	0.00	0.00	NA	0.00	XXX
78816	TC	C	Pet image w/ct, full body	0.00	0.00	NA	0.00	XXX
78816	26	A	Pet image w/ct, full body	2.50	0.68	0.68	0.17	XXX
78999		C	Nuclear diagnostic exam	0.00	0.00	NA	0.00	XXX
78999	TC	C	Nuclear diagnostic exam	0.00	0.00	NA	0.00	XXX
78999	26	C	Nuclear diagnostic exam	0.00	0.00	0.00	0.00	XXX
79005		A	Nuclear rx, oral admin	1.80	1.61	NA	0.10	XXX
79005	TC	A	Nuclear rx, oral admin	0.00	1.08	NA	0.01	XXX
79005	26	A	Nuclear rx, oral admin	1.80	0.53	0.53	0.09	XXX
79101		A	Nuclear rx, iv admin	1.96	1.84	NA	0.10	XXX
79101	TC	A	Nuclear rx, iv admin	0.00	1.13	NA	0.01	XXX
79101	26	A	Nuclear rx, iv admin	1.96	0.72	0.72	0.09	XXX
79200		A	Nuclear rx, intracav admin	1.99	2.07	NA	0.14	XXX
79200	TC	A	Nuclear rx, intracav admin	0.00	1.45	NA	0.01	XXX
79200	26	A	Nuclear rx, intracav admin	1.99	0.62	0.62	0.14	XXX
79300		C	Nuclr rx, interstit colloid	0.00	0.00	NA	0.00	XXX
79300	TC	C	Nuclr rx, interstit colloid	0.00	0.00	NA	0.00	XXX
79300	26	A	Nuclr rx, interstit colloid	1.60	0.48	0.48	0.12	XXX
79403		A	Hematopoietic nuclear tx	2.25	2.43	NA	0.14	XXX
79403	TC	A	Hematopoietic nuclear tx	0.00	1.79	NA	0.01	XXX
79403	26	A	Hematopoietic nuclear tx	2.25	0.64	0.64	0.13	XXX
79440		A	Nuclear rx, intra-articular	1.99	1.66	NA	0.14	XXX
79440	TC	A	Nuclear rx, intra-articular	0.00	1.04	NA	0.01	XXX
79440	26	A	Nuclear rx, intra-articular	1.99	0.62	0.62	0.14	XXX
79445		C	Nuclear rx, intra-arterial	0.00	NA	NA	0.00	XXX
79445	TC	C	Nuclear rx, intra-arterial	0.00	NA	NA	0.00	XXX
79445	26	A	Nuclear rx, intra-arterial	2.40	0.62	0.62	0.15	XXX
79999		C	Nuclear medicine therapy	0.00	0.00	NA	0.00	XXX
79999	TC	C	Nuclear medicine therapy	0.00	0.00	NA	0.00	XXX
79999	26	C	Nuclear medicine therapy	0.00	0.00	0.00	0.00	XXX
80055		I	Obstetric panel	0.00	0.00	0.00	0.00	XXX
80500		A	Lab pathology consultation	0.37	0.17	0.11	0.02	XXX
80502		A	Lab pathology consultation	1.33	0.41	0.36	0.06	XXX
83020		X	Hemoglobin electrophoresis	0.00	0.10	NA	0.00	XXX
83020	26	A	Hemoglobin electrophoresis	0.37	0.15	0.15	0.02	XXX
83912		X	Genetic examination	0.00	0.08	NA	0.00	XXX
83912	26	A	Genetic examination	0.37	0.13	0.13	0.02	XXX
84165		X	Protein e-phoresis, serum	0.00	0.10	NA	0.00	XXX
84165	26	A	Protein e-phoresis, serum	0.37	0.14	0.14	0.02	XXX
84166		X	Protein e-phoresis/urine/csf	0.00	0.10	NA	0.00	XXX

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84166	26	A	Protein e-phoresis/urine/csf	0.37	0.14	0.14	0.02	XXX
84181		X	Western blot test	0.00	0.10	NA	0.00	XXX
84181	26	A	Western blot test	0.37	0.15	0.15	0.02	XXX
84182		X	Protein, western blot test	0.00	0.10	NA	0.00	XXX
84182	26	A	Protein, western blot test	0.37	0.15	0.15	0.02	XXX
85060		A	Blood smear interpretation	0.45	0.18	0.18	0.02	XXX
85097		A	Bone marrow interpretation	0.94	1.16	0.32	0.04	XXX
85390		X	Fibrinolysins screen	0.00	0.09	NA	0.00	XXX
85390	26	A	Fibrinolysins screen	0.37	0.15	0.15	0.02	XXX
85396		A	Clotting assay, whole blood	0.37	NA	0.13	0.02	XXX
85576		X	Blood platelet aggregation	0.00	0.10	NA	0.00	XXX
85576	26	A	Blood platelet aggregation	0.37	0.15	0.15	0.02	XXX
86077		A	Physician blood bank service	0.94	0.45	0.37	0.04	XXX
86078		A	Physician blood bank service	0.94	0.45	0.37	0.04	XXX
86079		A	Physician blood bank service	0.94	0.45	0.37	0.04	XXX
86255		X	Fluorescent antibody, screen	0.00	0.11	NA	0.00	XXX
86255	26	A	Fluorescent antibody, screen	0.37	0.15	0.15	0.02	XXX
86256		X	Fluorescent antibody, titer	0.00	0.10	NA	0.00	XXX
86256	26	A	Fluorescent antibody, titer	0.37	0.14	0.14	0.02	XXX
86320		X	Serum immunoelectrophoresis	0.00	0.09	NA	0.00	XXX
86320	26	A	Serum immunoelectrophoresis	0.37	0.14	0.14	0.02	XXX
86325		X	Other immunoelectrophoresis	0.00	0.10	NA	0.00	XXX
86325	26	A	Other immunoelectrophoresis	0.37	0.14	0.14	0.02	XXX
86327		X	Immunoelectrophoresis assay	0.00	0.10	NA	0.00	XXX
86327	26	A	Immunoelectrophoresis assay	0.42	0.17	0.17	0.02	XXX
86334		X	Immunofix e-phoresis, serum	0.00	0.10	NA	0.00	XXX
86334	26	A	Immunofix e-phoresis, serum	0.37	0.14	0.14	0.02	XXX
86335		X	Immunfix e-phorsis/urine/csf	0.00	0.10	NA	0.00	XXX
86335	26	A	Immunfix e-phorsis/urine/csf	0.37	0.15	0.15	0.02	XXX
86485		C	Skin test, candida	0.00	0.00	NA	0.00	XXX
86486		A	Coccidioidomycosis skin test	0.00	0.11	NA	0.00	XXX
86490		A	Histoplasmosis skin test	0.00	0.14	NA	0.00	XXX
86510		A	TB intradermal test	0.00	0.17	NA	0.00	XXX
86580		X	Dark field examination	0.00	0.10	NA	0.00	XXX
87164	26	A	Dark field examination	0.37	0.15	0.15	0.02	XXX
87207		X	Smear, special stain	0.00	0.10	NA	0.00	XXX
87207	26	A	Smear, special stain	0.37	0.15	0.15	0.02	XXX
88104		A	Cytopath fl nongyn, smears	0.56	1.13	NA	0.03	XXX
88104	TC	A	Cytopath fl nongyn, smears	0.00	0.93	NA	0.00	XXX
88104	26	A	Cytopath fl nongyn, smears	0.56	0.20	0.20	0.03	XXX
88106		A	Cytopath fl nongyn, filter	0.56	1.51	NA	0.03	XXX
88106	TC	A	Cytopath fl nongyn, filter	0.00	0.31	0.31	0.00	XXX
88106	26	A	Cytopath fl nongyn, filter	0.56	0.20	0.20	0.02	XXX
88107		A	Cytopath fl nongyn, sm/fltr	0.76	1.89	NA	0.04	XXX
88107	TC	A	Cytopath fl nongyn, sm/fltr	0.00	1.61	NA	0.00	XXX
88107	26	A	Cytopath fl nongyn, sm/fltr	0.76	0.28	0.28	0.03	XXX
88108		A	Cytopath, concentrate tech	0.56	1.34	NA	0.03	XXX
88108	TC	A	Cytopath, concentrate tech	0.00	1.15	NA	0.00	XXX
88108	26	A	Cytopath, concentrate tech	0.56	0.19	0.19	0.03	XXX
88112		A	Cytopath, cell enhance tech	1.18	1.38	NA	0.06	XXX
88112	TC	A	Cytopath, cell enhance tech	0.00	1.02	NA	0.00	XXX
88112	26	A	Cytopath, cell enhance tech	1.18	0.36	0.36	0.06	XXX
88125		A	Forensic cytopathology	0.26	0.31	NA	0.01	XXX
88125	TC	A	Forensic cytopathology	0.00	0.21	NA	0.00	XXX
88125	26	A	Forensic cytopathology	0.26	0.10	0.10	0.01	XXX
88141		A	Cytopath, c/v, interpret	0.42	0.35	0.35	0.02	XXX
88150		X	Cytopath, c/v, manual	0.00	1.06	NA	0.00	XXX
88160		A	Cytopath smear, other source	0.50	0.85	NA	0.02	XXX
88160	TC	A	Cytopath smear, other source	0.00	0.68	NA	0.00	XXX
88160	26	A	Cytopath smear, other source	0.50	0.16	0.16	0.02	XXX
88161		A	Cytopath smear, other source	0.50	0.85	NA	0.02	XXX
88161	TC	A	Cytopath smear, other source	0.00	0.69	NA	0.00	XXX
88161	26	A	Cytopath smear, other source	0.50	0.15	0.15	0.02	XXX
88162		A	Cytopath smear, other source	0.76	1.00	NA	0.04	XXX
88162	TC	A	Cytopath smear, other source	0.00	0.81	NA	0.00	XXX
88162	26	A	Cytopath smear, other source	0.76	0.19	0.19	0.03	XXX
88172		A	Cytopathology eval of fna	0.60	0.85	NA	0.03	XXX
88172	TC	A	Cytopathology eval of fna	0.00	0.62	NA	0.00	XXX
88172	26	A	Cytopathology eval of fna	0.60	0.23	0.23	0.03	XXX
88173		A	Cytopath eval, fna, report	1.39	2.14	NA	0.07	XXX
88173	TC	A	Cytopath eval, fna, report	0.00	1.66	NA	0.00	XXX
88173	26	A	Cytopath eval, fna, report	1.39	0.48	0.48	0.06	XXX
88182		A	Cell marker study	0.77	1.79	NA	0.04	XXX
88182	TC	A	Cell marker study	0.00	1.62	NA	0.00	XXX
88182	26	A	Cell marker study	0.77	0.18	0.18	0.03	XXX
88184		A	Flowcytometry/ tc, 1 marker	0.00	2.00	NA	0.00	XXX
88185		A	Flowcytometry/tc, add-on	0.00	1.22	NA	0.00	ZZZ
88187		A	Flowcytometry/read, 2-8	1.36	0.47	0.47	0.06	XXX
88188		A	Flowcytometry/read, 9-15	1.69	0.60	0.60	0.08	XXX
88189		A	Flowcytometry/read, 16 & >	2.23	0.57	0.57	0.11	XXX
88199		C	Cytopathology procedure	0.00	0.00	NA	0.00	XXX
88199	TC	C	Cytopathology procedure	0.00	0.00	NA	0.00	XXX
88199	26	C	Cytopathology procedure	0.00	0.00	0.00	0.00	XXX

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[4] Global totals for malpractice RVUs may not sum due to rounding.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
88291		A	Cyto/molecular report	0.52	0.25	0.25	0.02	XXX
88299		C	Cytogenetic study	0.00	0.00	0.00	0.00	XXX
88300		A	Surgical path, gross	0.08	0.54	NA	0.00	XXX
88300	TC	A	Surgical path, gross	0.00	0.51	NA	0.00	XXX
88300	26	A	Surgical path, gross	0.08	0.03	0.03	0.00	XXX
88302		A	Tissue exam by pathologist	0.13	1.16	NA	0.01	XXX
88302	TC	A	Tissue exam by pathologist	0.00	1.12	NA	0.00	XXX
88302	26	A	Tissue exam by pathologist	0.13	0.05	0.05	0.01	XXX
88304		A	Tissue exam by pathologist	0.22	1.39	NA	0.01	XXX
88304	TC	A	Tissue exam by pathologist	0.00	1.31	NA	0.00	XXX
88304	26	A	Tissue exam by pathologist	0.22	0.08	0.08	0.01	XXX
88305		A	Tissue exam by pathologist	0.75	1.91	NA	0.03	XXX
88305	TC	A	Tissue exam by pathologist	0.00	1.66	NA	0.00	XXX
88305	26	A	Tissue exam by pathologist	0.75	0.26	0.26	0.03	XXX
88307		A	Tissue exam by pathologist	1.59	4.25	NA	0.07	XXX
88307	TC	A	Tissue exam by pathologist	0.00	3.66	NA	0.00	XXX
88307	26	A	Tissue exam by pathologist	1.59	0.60	0.60	0.07	XXX
88309		A	Tissue exam by pathologist	2.80	6.14	NA	0.13	XXX
88309	TC	A	Tissue exam by pathologist	0.00	5.09	NA	0.01	XXX
88309	26	A	Tissue exam by pathologist	2.80	1.06	1.06	0.12	XXX
88311		A	Decalcify tissue	0.24	0.25	NA	0.01	XXX
88311	TC	A	Decalcify tissue	0.00	0.16	NA	0.00	XXX
88311	26	A	Decalcify tissue	0.24	0.09	0.09	0.01	XXX
88312		A	Special stains	0.54	2.13	NA	0.02	XXX
88312	TC	A	Special stains	0.00	1.96	NA	0.00	XXX
88312	26	A	Special stains	0.54	0.18	0.18	0.02	XXX
88313		A	Special stains	0.24	1.67	NA	0.01	XXX
88313	TC	A	Special stains	0.00	1.59	NA	0.00	XXX
88313	26	A	Special stains	0.24	0.08	0.08	0.01	XXX
88314		A	Histochemical stain	0.45	1.72	NA	0.02	XXX
88314	TC	A	Histochemical stain	0.00	1.56	NA	0.00	XXX
88314	26	A	Histochemical stain	0.45	0.17	0.17	0.02	XXX
88318		A	Chemical histochemistry	0.42	2.14	NA	0.02	XXX
88318	TC	A	Chemical histochemistry	0.00	2.01	NA	0.00	XXX
88318	26	A	Chemical histochemistry	0.42	0.12	0.12	0.02	XXX
88319		A	Enzyme histochemistry	0.53	3.01	NA	0.03	XXX
88319	TC	A	Enzyme histochemistry	0.00	2.82	NA	0.00	XXX
88319	26	A	Enzyme histochemistry	0.53	0.19	0.19	0.03	XXX
88321		A	Microslide consultation	1.63	0.79	0.58	0.07	XXX
88323		A	Microslide consultation	1.83	1.88	NA	0.08	XXX
88323	TC	A	Microslide consultation	0.00	1.38	NA	0.01	XXX
88323	26	A	Microslide consultation	1.83	0.50	0.50	0.08	XXX
88325		A	Comprehensive review of data	2.50	2.78	1.02	0.11	XXX
88329		A	Path consult introp	0.67	0.69	0.25	0.03	XXX
88331		A	Path consult intraop, 1 bloc	1.19	1.25	NA	0.04	XXX
88331	TC	A	Path consult intraop, 1 bloc	0.00	0.79	NA	0.00	XXX
88331	26	A	Path consult intraop, 1 bloc	1.19	0.47	0.47	0.04	XXX
88332		A	Path consult intraop, addÆl	0.59	0.49	NA	0.03	XXX
88332	TC	A	Path consult intraop, addÆl	0.00	0.27	NA	0.00	XXX
88332	26	A	Path consult intraop, addÆl	0.59	0.22	0.22	0.03	XXX
88333		A	Intraop cyto path consult, 1	1.20	1.34	NA	0.06	XXX
88333	TC	A	Intraop cyto path consult, 1	0.00	0.89	NA	0.00	XXX
88333	26	A	Intraop cyto path consult, 1	1.20	0.45	0.45	0.05	XXX
88334		A	Intraop cyto path consult, 2	0.73	0.83	NA	0.03	XXX
88334	TC	A	Intraop cyto path consult, 2	0.00	0.55	NA	0.00	XXX
88334	26	A	Intraop cyto path consult, 2	0.73	0.28	0.28	0.03	XXX
88342		A	Immunohistochemistry	0.85	1.81	NA	0.04	XXX
88342	TC	A	Immunohistochemistry	0.00	1.54	NA	0.00	XXX
88342	26	A	Immunohistochemistry	0.85	0.28	0.28	0.04	XXX
88346		A	Immunofluorescent study	0.86	1.73	NA	0.04	XXX
88346	TC	A	Immunofluorescent study	0.00	1.45	NA	0.00	XXX
88346	26	A	Immunofluorescent study	0.86	0.28	0.28	0.03	XXX
88347		A	Immunofluorescent study	0.86	1.13	NA	0.03	XXX
88347	TC	A	Immunofluorescent study	0.00	0.92	NA	0.00	XXX
88347	26	A	Immunofluorescent study	0.86	0.21	0.21	0.03	XXX
88348		A	Electron microscopy	1.51	15.15	NA	0.07	XXX
88348	TC	A	Electron microscopy	0.00	14.67	NA	0.00	XXX
88348	26	A	Electron microscopy	1.51	0.49	0.49	0.07	XXX
88349		A	Scanning electron microscopy	0.76	8.92	NA	0.05	XXX
88349	TC	A	Scanning electron microscopy	0.00	8.62	NA	0.00	XXX
88349	26	A	Scanning electron microscopy	0.76	0.30	0.30	0.04	XXX
88355		A	Analysis, skeletal muscle	1.85	2.63	NA	0.05	XXX
88355	TC	A	Analysis, skeletal muscle	0.00	2.23	NA	0.01	XXX
88355	26	A	Analysis, skeletal muscle	1.85	0.40	0.40	0.05	XXX
88356		A	Analysis, nerve	3.02	4.02	NA	0.18	XXX
88356	TC	A	Analysis, nerve	0.00	3.52	NA	0.01	XXX
88356	26	A	Analysis, nerve	3.02	0.50	0.50	0.17	XXX
88358		A	Analysis, tumor	0.95	0.97	NA	0.05	XXX
88358	TC	A	Analysis, tumor	0.00	0.78	NA	0.00	XXX
88358	26	A	Analysis, tumor	0.95	0.19	0.19	0.04	XXX
88360		A	Tumor immunohistochem/manual	1.10	2.09	NA	0.05	XXX
88360	TC	A	Tumor immunohistochem/manual	0.00	1.75	NA	0.00	XXX
88360	26	A	Tumor immunohistochem/manual	1.10	0.35	0.35	0.05	XXX
88361		A	Tumor immunohistochem/comput	1.18	2.50	NA	0.06	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
88361	TC	A	Tumor immunohistochem/comput	0.00	2.16	NA	0.00	XXX
88361	26	A	Tumor immunohistochem/comput	1.18	0.34	0.34	0.05	XXX
88362		A	Nerve teasing preparations	2.17	5.22	NA	0.13	XXX
88362	TC	A	Nerve teasing preparations	0.00	4.45	NA	0.01	XXX
88362	26	A	Nerve teasing preparations	2.17	0.77	0.77	0.12	XXX
88365		A	Insitu hybridization (fish)	1.20	3.03	NA	0.06	XXX
88365	TC	A	Insitu hybridization (fish)	0.00	2.66	NA	0.00	XXX
88365	26	A	Insitu hybridization (fish)	1.20	0.37	0.37	0.05	XXX
88367		A	Insitu hybridization, auto	1.30	4.92	NA	0.08	XXX
88367	TC	A	Insitu hybridization, auto	0.00	4.59	NA	0.00	XXX
88367	26	A	Insitu hybridization, auto	1.30	0.33	0.33	0.07	XXX
88368		A	Insitu hybridization, manual	1.40	4.07	NA	0.07	XXX
88368	TC	A	Insitu hybridization, manual	0.00	3.80	NA	0.00	XXX
88368	26	A	Insitu hybridization, manual	1.40	0.28	0.28	0.06	XXX
88371		X	Protein, western blot tissue	0.00	0.10	NA	0.00	XXX
88371	26	A	Protein, western blot tissue	0.37	0.15	0.15	0.02	XXX
88372		X	Protein analysis w/probe	0.00	0.10	NA	0.00	XXX
88372	26	A	Protein analysis w/probe	0.37	0.15	0.15	0.02	XXX
88380		A	Microdissection, laser	1.56	3.59	NA	0.07	XXX
88380	TC	A	Microdissection, laser	0.00	2.99	NA	0.00	XXX
88380	26	A	Microdissection, laser	1.56	0.60	0.60	0.07	XXX
88381		A	Microdissection, manual	1.18	2.43	NA	0.06	XXX
88381	TC	A	Microdissection, manual	0.00	2.23	NA	0.00	XXX
88381	26	A	Microdissection, manual	1.18	0.21	0.21	0.05	XXX
88384		C	Eval molecular probes, 11-50	0.00	0.00	NA	0.00	XXX
88384	TC	C	Eval molecular probes, 11-50	0.00	0.00	NA	0.00	XXX
88384	26	C	Eval molecular probes, 11-50	0.00	0.00	0.00	0.00	XXX
88385		A	Eval molecul probes, 51-250	1.50	23.03	NA	0.07	XXX
88385	TC	A	Eval molecul probes, 51-250	0.00	22.44	NA	0.00	XXX
88385	26	A	Eval molecul probes, 51-250	1.50	0.59	0.59	0.07	XXX
88386		A	Eval molecul probes, 251-500	1.88	14.49	NA	0.09	XXX
88386	TC	A	Eval molecul probes, 251-500	0.00	13.94	NA	0.01	XXX
88386	26	A	Eval molecul probes, 251-500	1.88	0.55	0.55	0.08	XXX
88399		C	Surgical pathology procedure	0.00	0.00	NA	0.00	XXX
88399	TC	C	Surgical pathology procedure	0.00	0.00	NA	0.00	XXX
88399	26	C	Surgical pathology procedure	0.00	0.00	0.00	0.00	XXX
89049		A	Chct for mal hyperthermia	1.40	5.43	0.51	0.07	XXX
89060		X	Exam,synovial fluid crystals	0.00	0.10	NA	0.00	XXX
89060	26	A	Exam,synovial fluid crystals	0.37	0.14	0.14	0.02	XXX
89100		A	Sample intestinal contents	0.60	7.69	0.54	0.03	XXX
89105		A	Sample intestinal contents	0.50	6.89	0.44	0.02	XXX
89130		A	Sample stomach contents	0.45	6.41	0.40	0.02	XXX
89132		A	Sample stomach contents	0.19	6.44	0.30	0.01	XXX
89135		A	Sample stomach contents	0.79	7.67	0.61	0.04	XXX
89136		A	Sample stomach contents	0.21	6.41	0.31	0.01	XXX
89140		A	Sample stomach contents	0.94	6.81	0.58	0.05	XXX
89141		A	Sample stomach contents	0.85	6.77	0.54	0.05	XXX
89220		A	Sputum specimen collection	0.00	0.37	NA	0.00	XXX
89230		A	Collect sweat for test	0.00	0.16	NA	0.00	XXX
89240		C	Pathology lab procedure	0.00	0.00	0.00	0.00	XXX
90281		I	Human ig, im	0.00	0.00	0.00	0.00	XXX
90283		I	Human ig, iv	0.00	0.00	0.00	0.00	XXX
90287		I	Botulinum antitoxin	0.00	0.00	0.00	0.00	XXX
90288		I	Botulism ig, iv	0.00	0.00	0.00	0.00	XXX
90291		I	Cmv ig, iv	0.00	0.00	0.00	0.00	XXX
90379		I	Rsv ig, iv	0.00	0.00	0.00	0.00	XXX
90384		I	Rh ig, full-dose, im	0.00	0.00	0.00	0.00	XXX
90386		I	Rh ig, iv	0.00	0.00	0.00	0.00	XXX
90389		I	Tetanus ig, im	0.00	0.00	0.00	0.00	XXX
90399		I	Immune globulin	0.00	0.00	0.00	0.00	XXX
90465		A	Immune admin 1 inj, < 8 yrs	0.17	0.42	NA	0.01	XXX
90466		A	Immune admin addl inj, < 8 y	0.15	0.16	0.06	0.01	ZZZ
90467		R	Immune admin o or n, < 8 yrs	0.17	0.27	0.10	0.01	XXX
90468		R	Immune admin o/n, addl < 8 y	0.15	0.15	0.06	0.01	ZZZ
90471		A	Immunization admin	0.17	0.42	NA	0.01	XXX
90472		A	Immunization admin, each add	0.15	0.17	0.06	0.01	ZZZ
90473		R	Immune admin oral/nasal	0.17	0.26	0.07	0.01	XXX
90474		R	Immune admin oral/nasal addl	0.15	0.12	0.06	0.01	ZZZ
90723		I	Dtap-hep b-ipv vaccine, im	0.00	0.00	0.00	0.00	XXX
90738		I	Inactivated je vacc im	0.00	0.00	0.00	0.00	XXX
90748		I	Hep b/hib vaccine, im	0.00	0.00	0.00	0.00	XXX
90801		A	Psy dx interview	2.80	1.31	0.50	0.09	XXX
90802		A	Intac psy dx interview	3.01	1.49	0.59	0.10	XXX
90804		A	Psytx, office, 20-30 min	1.21	0.47	0.15	0.04	XXX
90805		A	Psytx, off, 20-30 min w/e&m	1.37	0.59	0.23	0.05	XXX
90806		A	Psytx, off, 45-50 min	1.86	0.38	0.20	0.05	XXX
90807		A	Psytx, off, 45-50 min w/e&m	2.02	0.69	0.34	0.07	XXX
90808		A	Psytx, office, 75-80 min	2.79	0.49	0.31	0.08	XXX
90809		A	Psytx, off, 75-80, w/e&m	2.95	0.85	0.52	0.10	XXX
90810		A	Intac psytx, off, 20-30 min	1.32	0.44	0.17	0.04	XXX
90811		A	Intac psytx, 20-30, w/e&m	1.48	0.71	0.26	0.05	XXX
90812		A	Intac psytx, off, 45-50 min	1.97	0.48	0.21	0.06	XXX
90813		A	Intac psytx, 45-50 min w/e&m	2.13	0.81	0.35	0.07	XXX
90814		A	Intac psytx, off, 75-80 min	2.90	0.65	0.32	0.09	XXX

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CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
90815		A	Intac psytx, 75-80 w/e&m	3.06	1.01	0.55	0.11	XXX
90816		A	Psytx, hosp, 20-30 min	1.25	NA	0.22	0.03	XXX
90817		A	Psytx, hosp, 20-30 min w/e&m	1.41	NA	0.34	0.05	XXX
90818		A	Psytx, hosp, 45-50 min	1.89	NA	0.28	0.05	XXX
90819		A	Psytx, hosp, 45-50 min w/e&m	2.05	NA	0.45	0.07	XXX
90821		A	Psytx, hosp, 75-80 min	2.83	NA	0.40	0.08	XXX
90822		A	Psytx, hosp, 75-80 min w/e&m	2.99	NA	0.60	0.10	XXX
90823		A	Intac psytx, hosp, 20-30 min	1.36	NA	0.22	0.04	XXX
90824		A	Intac psytx, hsp 20-30 w/e&m	1.52	NA	0.36	0.05	XXX
90826		A	Intac psytx, hosp, 45-50 min	2.01	NA	0.30	0.06	XXX
90827		A	Intac psytx, hsp 45-50 w/e&m	2.16	NA	0.46	0.07	XXX
90828		A	Intac psytx, hosp, 75-80 min	2.94	NA	0.38	0.08	XXX
90829		A	Intac psytx, hsp 75-80 w/e&m	3.10	NA	0.61	0.10	XXX
90845		A	Psychoanalysis	1.79	0.39	0.33	0.06	XXX
90846		R	Family psytx w/o patient	1.83	0.41	0.33	0.06	XXX
90847		R	Family psytx w/patient	2.21	0.59	0.36	0.07	XXX
90849		R	Multiple family group psytx	0.59	0.30	0.18	0.02	XXX
90853		A	Group psychotherapy	0.59	0.27	0.21	0.02	XXX
90857		A	Intac group psytx	0.63	0.33	0.19	0.02	XXX
90862		A	Medication management	0.95	0.62	0.27	0.03	XXX
90865		A	Narcosynthesis	2.84	1.47	0.57	0.10	XXX
90870		A	Electroconvulsive therapy	1.88	1.88	0.37	0.06	000
90875		N	Psychophysiological therapy	1.20	0.71	0.44	0.06	XXX
90876		N	Psychophysiological therapy	1.90	0.95	0.69	0.10	XXX
90880		A	Hypnotherapy	2.19	0.42	0.28	0.06	XXX
90885		B	Psy evaluation of records	0.97	0.35	0.35	0.05	XXX
90887		B	Consultation with family	1.48	0.83	0.54	0.08	XXX
90889		B	Preparation of report	0.00	0.00	0.00	0.00	XXX
90899		C	Psychiatric service/therapy	0.00	0.00	0.00	0.00	XXX
90901		A	Biofeedback train, any meth	0.41	0.54	0.13	0.02	000
90911		A	Biofeedback peri/uro/rectal	0.89	1.23	0.30	0.05	000
90935		A	Hemodialysis, one evaluation	1.22	NA	0.64	0.05	000
90937		A	Hemodialysis, repeated eval	2.11	NA	0.95	0.09	000
90940		X	Hemodialysis access study	0.00	0.37	NA	0.00	XXX
90945		A	Dialysis, one evaluation	1.28	NA	0.66	0.06	000
90947		A	Dialysis, repeated eval	2.16	NA	0.96	0.10	000
90951		A	Esrd serv, 4 visits p mo, <2	18.46	8.45	8.45	0.77	XXX
90952		C	Esrd serv, 2-3 vsts p mo, <2	0.00	0.00	0.00	0.00	XXX
90953		C	Esrd serv, 1 visit p mo, <2	0.00	0.00	0.00	0.00	XXX
90954		A	Esrd serv, 4 vsts p mo, 2-11	15.98	6.64	6.64	0.69	XXX
90955		A	Esrd srv 2-3 vsts p mo, 2-11	8.79	3.71	3.71	0.38	XXX
90956		A	Esrd srv, 1 visit p mo, 2-11	5.95	2.31	2.31	0.26	XXX
90957		A	Esrd srv, 4 vsts p mo, 12-19	12.52	5.61	5.61	0.55	XXX
90958		A	Esrd srv 2-3 vsts p mo 12-19	8.34	3.68	3.68	0.37	XXX
90959		A	Esrd serv, 1 vst p mo, 12-19	5.50	2.17	2.17	0.24	XXX
90960		A	Esrd srv, 4 visits p mo, 20+	5.18	2.73	2.73	0.23	XXX
90961		A	Esrd srv, 2-3 vsts p mo, 20+	4.26	2.06	2.06	0.19	XXX
90962		A	Esrd serv, 1 visit p mo, 20+	3.15	1.32	1.32	0.14	XXX
90963		A	Esrd home pt, serv p mo, <2	10.56	3.87	3.87	0.45	XXX
90964		A	Esrd home pt serv p mo, 2-11	9.14	3.41	3.41	0.40	XXX
90965		A	Esrd home pt serv p mo 12-19	8.69	3.27	3.27	0.38	XXX
90966		A	Esrd home pt, serv p mo, 20+	4.26	1.94	1.94	0.19	XXX
90967		A	Esrd home pt serv p day, <2	0.35	0.20	0.20	0.02	XXX
90968		A	Esrd home pt srv p day, 2-11	0.30	0.13	0.13	0.01	XXX
90969		A	Esrd home pt srv p day 12-19	0.29	0.13	0.13	0.01	XXX
90970		A	Esrd home pt serv p day, 20+	0.14	0.07	0.07	0.01	XXX
90997		A	Hemoperfusion	1.84	NA	0.61	0.08	000
90999		C	Dialysis procedure	0.00	0.00	0.00	0.00	XXX
91000		A	Esophageal intubation	0.73	2.14	2.14	0.04	000
91000	TC	A	Esophageal intubation	0.00	1.87	1.87	0.00	000
91000	26	A	Esophageal intubation	0.73	0.27	0.27	0.04	000
91010		A	Esophagus motility study	1.25	3.26	3.26	0.08	000
91010	TC	A	Esophagus motiity study	0.00	2.72	2.72	0.00	000
91010	26	A	Esophagus motility study	1.25	0.54	0.54	0.08	000
91011		A	Esophagus motility study	1.50	4.59	4.59	0.08	000
91011	TC	A	Esophagus motility study	0.00	3.92	3.92	0.00	000
91011	26	A	Esophagus motility study	1.50	0.67	0.67	0.08	000
91012		A	Esophagus motility study	1.46	4.68	4.68	0.08	000
91012	TC	A	Esophagus motility study	0.00	4.04	4.04	0.00	000
91012	26	A	Esophagus motility study	1.46	0.64	0.64	0.08	000
91020		A	Gastric motility studies	1.44	4.37	4.37	0.09	000
91020	TC	A	Gastric motility studies	0.00	3.75	3.75	0.00	000
91020	26	A	Gastric motility studies	1.44	0.62	0.62	0.08	000
91022		A	Duodenal motility study	1.44	2.88	2.88	0.08	000
91022	TC	A	Duodenal motility study	0.00	2.24	2.24	0.00	000
91022	26	A	Duodenal motility study	1.44	0.64	0.64	0.08	000
91030		A	Acid perfusion of esophagus	0.91	2.51	2.51	0.05	000
91030	TC	A	Acid perfusion of esophagus	0.00	2.11	2.11	0.00	000
91030	26	A	Acid perfusion of esophagus	0.91	0.40	0.40	0.05	000
91034		A	Gastroesophageal reflux test	0.97	3.70	3.70	0.05	000
91034	TC	A	Gastroesophageal reflux test	0.00	3.28	3.28	0.00	000
91034	26	A	Gastroesophageal reflux test	0.97	0.42	0.42	0.05	000
91035		A	G-esoph reflx tst w/electrod	1.59	10.10	10.10	0.10	000
91035	TC	A	G-esoph reflx tst w/electrod	0.00	9.41	9.41	0.00	000

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CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
91035	26	A	G-esoph reflx tst w/electrod	1.59	0.69	0.69	0.09	000
91037		A	Esoph imped function test	0.97	3.03	3.03	0.08	000
91037	TC	A	Esoph imped function test	0.00	2.61	2.61	0.00	000
91037	26	A	Esoph imped function test	0.97	0.42	0.42	0.08	000
91038		A	Esoph imped funct test > 1h	1.10	2.43	2.43	0.07	000
91038	TC	A	Esoph imped funct test > 1h	0.00	1.95	1.95	0.00	000
91038	26	A	Esoph imped funct test > 1h	1.10	0.48	0.48	0.07	000
91040		A	Esoph balloon distension tst	0.97	6.23	6.23	0.04	000
91040	TC	A	Esoph balloon distension tst	0.00	5.91	5.91	0.00	000
91040	26	A	Esoph balloon distension tst	0.97	0.32	0.32	0.04	000
91052		A	Gastric analysis test	0.79	2.55	2.55	0.03	000
91052	TC	A	Gastric analysis test	0.00	2.19	2.19	0.00	000
91052	26	A	Gastric analysis test	0.79	0.35	0.35	0.03	000
91055		A	Gastric intubation for smear	0.94	2.92	2.92	0.04	000
91055	TC	A	Gastric intubation for smear	0.00	2.46	2.46	0.00	000
91055	26	A	Gastric intubation for smear	0.94	0.46	0.46	0.04	000
91065		A	Breath hydrogen test	0.20	1.55	1.55	0.01	000
91065	TC	A	Breath hydrogen test	0.00	1.46	1.46	0.00	000
91065	26	A	Breath hydrogen test	0.20	0.09	0.09	0.01	000
91105		A	Gastric intubation treatment	0.37	1.99	0.09	0.02	000
91110		A	Gi tract capsule endoscopy	3.64	18.12	NA	0.21	XXX
91110	TC	A	Gi tract capsule endoscopy	0.00	16.52	NA	0.01	XXX
91110	26	A	Gi tract capsule endoscopy	3.64	1.60	1.60	0.20	XXX
91111		A	Esophageal capsule endoscopy	1.00	16.32	NA	0.05	XXX
91111	TC	A	Esophageal capsule endoscopy	0.00	15.88	NA	0.00	XXX
91111	26	A	Esophageal capsule endoscopy	1.00	0.44	0.44	0.05	XXX
91120		A	Rectal sensation test	0.97	8.82	8.82	0.09	XXX
91120	TC	A	Rectal sensation test	0.00	8.45	8.45	0.00	XXX
91120	26	A	Rectal sensation test	0.97	0.38	0.38	0.09	XXX
91122		A	Anal pressure record	1.77	3.78	3.78	0.12	000
91122	TC	A	Anal pressure record	0.00	3.14	3.14	0.01	000
91122	26	A	Anal pressure record	1.77	0.64	0.64	0.11	000
91123		B	Irrigate fecal impaction	0.00	NA	NA	0.00	XXX
91132		C	Electrogastrography	0.00	0.00	NA	0.00	XXX
91132	TC	C	Electrogastrography	0.00	0.00	NA	0.00	XXX
91132	26	A	Electrogastrography	0.52	0.21	0.21	0.02	XXX
91133		C	Electrogastrography w/test	0.00	0.00	NA	0.00	XXX
91133	TC	C	Electrogastrography w/test	0.00	0.00	NA	0.00	XXX
91133	26	A	Electrogastrography w/test	0.66	0.29	0.29	0.04	XXX
91299		C	Gastroenterology procedure	0.00	0.00	NA	0.00	XXX
91299	TC	C	Gastroenterology procedure	0.00	0.00	NA	0.00	XXX
91299	26	C	Gastroenterology procedure	0.00	0.00	0.00	0.00	XXX
92002		A	Eye exam, new patient	0.88	1.18	0.41	0.03	XXX
92004		A	Eye exam, new patient	1.82	2.04	0.89	0.05	XXX
92012		A	Eye exam established pat	0.92	1.27	0.51	0.03	XXX
92014		A	Eye exam & treatment	1.42	1.78	0.75	0.04	XXX
92015		N	Refraction	0.38	0.15	0.14	0.02	XXX
92018		A	New eye exam & treatment	2.50	NA	1.42	0.08	XXX
92019		A	Eye exam & treatment	1.31	NA	0.58	0.04	XXX
92020		A	Special eye evaluation	0.37	0.34	0.20	0.01	XXX
92025		A	Corneal topography	0.35	0.61	0.61	0.01	XXX
92025	TC	A	Corneal topography	0.00	0.42	0.42	0.00	XXX
92025	26	A	Corneal topography	0.35	0.19	0.19	0.01	XXX
92060		A	Special eye evaluation	0.69	0.98	NA	0.02	XXX
92060	TC	A	Special eye evaluation	0.00	0.62	NA	0.00	XXX
92060	26	A	Special eye evaluation	0.69	0.36	0.36	0.02	XXX
92065		A	Orthoptic/pleoptic training	0.37	1.00	NA	0.01	XXX
92065	TC	A	Orthoptic/pleoptic training	0.00	0.87	NA	0.00	XXX
92065	26	A	Orthoptic/pleoptic training	0.37	0.13	0.13	0.01	XXX
92070		A	Fitting of contact lens	0.70	1.12	0.36	0.02	XXX
92081		A	Visual field examination(s)	0.36	1.13	NA	0.01	XXX
92081	TC	A	Visual field examination(s)	0.00	0.96	NA	0.00	XXX
92081	26	A	Visual field examination(s)	0.36	0.17	0.17	0.01	XXX
92082		A	Visual field examination(s)	0.44	1.55	NA	0.01	XXX
92082	TC	A	Visual field examination(s)	0.00	1.33	NA	0.00	XXX
92082	26	A	Visual field examination(s)	0.44	0.22	0.22	0.01	XXX
92083		A	Visual field examination(s)	0.50	1.79	NA	0.01	XXX
92083	TC	A	Visual field examination(s)	0.00	1.52	NA	0.00	XXX
92083	26	A	Visual field examination(s)	0.50	0.27	0.27	0.01	XXX
92100		A	Serial tonometry exam(s)	0.92	1.56	0.46	0.03	XXX
92120		A	Tonography & eye evaluation	0.81	1.21	0.40	0.02	XXX
92130		A	Water provocation tonography	0.81	1.46	0.44	0.03	XXX
92135		A	Ophth dx imaging post seg	0.35	0.95	NA	0.01	XXX
92135	TC	A	Ophth dx imaging post seg	0.00	0.76	NA	0.00	XXX
92135	26	A	Ophth dx imaging post seg	0.35	0.19	0.19	0.01	XXX
92136		A	Ophthalmic biometry	0.54	1.69	NA	0.02	XXX
92136	TC	A	Ophthalmic biometry	0.00	1.38	NA	0.00	XXX
92136	26	A	Ophthalmic biometry	0.54	0.32	0.32	0.01	XXX
92140		A	Glaucoma provocative tests	0.50	1.09	0.24	0.02	XXX
92225		A	Special eye exam, initial	0.38	0.33	0.20	0.01	XXX
92226		A	Special eye exam, subsequent	0.33	0.32	0.19	0.01	XXX
92230		A	Eye exam with photos	0.60	0.88	0.32	0.02	XXX
92235		A	Eye exam with photos	0.81	2.69	NA	0.02	XXX
92235	TC	A	Eye exam with photos	0.00	2.21	NA	0.00	XXX

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CPT[1,2]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
92235	26	A	Eye exam with photos	0.81	0.48	0.48	0.02	XXX
92240		A	Icg angiography	1.10	5.11	NA	0.03	XXX
92240	TC	A	Icg angiography	0.00	4.46	NA	0.00	XXX
92240	26	A	Icg angiography	1.10	0.65	0.65	0.03	XXX
92250		A	Eye exam with photos	0.44	1.52	NA	0.01	XXX
92250	TC	A	Eye exam with photos	0.00	1.30	NA	0.00	XXX
92250	26	A	Eye exam with photos	0.44	0.22	0.22	0.01	XXX
92260		A	Ophthalmoscopy/dynamometry	0.20	0.29	0.11	0.01	XXX
92265		A	Eye muscle evaluation	0.81	1.36	NA	0.02	XXX
92265	TC	A	Eye muscle evaluation	0.00	0.89	NA	0.00	XXX
92265	26	A	Eye muscle evaluation	0.81	0.47	0.47	0.02	XXX
92270		A	Electro-oculography	0.81	1.49	NA	0.04	XXX
92270	TC	A	Electro-oculography	0.00	1.16	NA	0.00	XXX
92270	26	A	Electro-oculography	0.81	0.33	0.33	0.03	XXX
92275		A	Electroretinography	1.01	2.94	NA	0.03	XXX
92275	TC	A	Electroretinography	0.00	2.36	NA	0.00	XXX
92275	26	A	Electroretinography	1.01	0.58	0.58	0.03	XXX
92283		A	Color vision examination	0.17	1.17	NA	0.00	XXX
92283	TC	A	Color vision examination	0.00	1.08	NA	0.00	XXX
92283	26	A	Color vision examination	0.17	0.08	0.08	0.00	XXX
92284		A	Dark adaptation eye exam	0.24	1.25	NA	0.01	XXX
92284	TC	A	Dark adaptation eye exam	0.00	1.15	NA	0.00	XXX
92284	26	A	Dark adaptation eye exam	0.24	0.10	0.10	0.01	XXX
92285		A	Eye photography	0.20	0.92	NA	0.01	XXX
92285	TC	A	Eye photography	0.00	0.82	NA	0.00	XXX
92285	26	A	Eye photography	0.20	0.10	0.10	0.01	XXX
92286		A	Internal eye photography	0.66	2.45	NA	0.02	XXX
92286	TC	A	Internal eye photography	0.00	2.09	NA	0.00	XXX
92286	26	A	Internal eye photography	0.66	0.36	0.36	0.02	XXX
92287		A	Internal eye photography	0.81	2.30	0.47	0.02	XXX
92310		N	Contact lens fitting	1.17	1.28	0.43	0.06	XXX
92311		A	Contact lens fitting	1.08	1.60	0.49	0.04	XXX
92312		A	Contact lens fitting	1.26	1.85	0.55	0.04	XXX
92313		A	Contact lens fitting	0.92	1.75	0.50	0.03	XXX
92314		N	Prescription of contact lens	0.69	1.31	0.25	0.04	XXX
92315		A	Prescription of contact lens	0.45	1.48	0.19	0.01	XXX
92316		A	Prescription of contact lens	0.68	2.00	0.40	0.02	XXX
92317		A	Prescription of contact lens	0.45	2.22	0.07	0.02	XXX
92325		A	Modification of contact lens	0.00	0.95	NA	0.00	XXX
92326		A	Replacement of contact lens	0.00	0.82	NA	0.00	XXX
92340		N	Fitting of spectacles	0.37	0.52	0.14	0.02	XXX
92341		N	Fitting of spectacles	0.47	0.56	0.17	0.03	XXX
92342		N	Fitting of spectacles	0.53	0.58	0.19	0.03	XXX
92352		B	Special spectacles fitting	0.37	0.65	0.14	0.02	XXX
92353		B	Special spectacles fitting	0.50	0.70	0.18	0.03	XXX
92354		B	Special spectacles fitting	0.00	0.31	NA	0.00	XXX
92355		B	Special spectacles fitting	0.00	0.48	NA	0.00	XXX
92358		B	Eye prosthesis service	0.00	0.26	NA	0.00	XXX
92370		N	Repair & adjust spectacles	0.32	0.46	0.12	0.02	XXX
92371		B	Repair & adjust spectacles	0.00	0.26	NA	0.00	XXX
92499		C	Eye service or procedure	0.00	0.00	NA	0.00	XXX
92499	TC	C	Eye service or procedure	0.00	0.00	NA	0.00	XXX
92499	26	C	Eye service or procedure	0.00	0.00	0.00	0.00	XXX
92502		A	Ear and throat examination	1.51	NA	1.12	0.06	000
92504		A	Ear microscopy examination	0.18	0.63	0.08	0.01	XXX
92506		A	Speech/hearing evaluation	0.86	3.68	0.38	0.04	XXX
92507		A	Speech/hearing therapy	0.52	1.37	0.21	0.02	XXX
92508		A	Speech/hearing therapy	0.26	0.77	0.12	0.01	XXX
92511		A	Nasopharyngoscopy	0.84	3.23	0.78	0.04	000
92512		A	Nasal function studies	0.55	1.04	0.25	0.02	XXX
92516		A	Facial nerve function test	0.43	1.27	0.19	0.02	XXX
92520		A	Laryngeal function studies	0.75	1.10	0.36	0.03	XXX
92526		A	Oral function therapy	0.55	1.89	0.21	0.02	XXX
92531		B	Spontaneous nystagmus study	0.00	0.00	0.00	0.00	XXX
92532		B	Positional nystagmus test	0.00	0.00	0.00	0.00	XXX
92533		B	Caloric vestibular test	0.00	0.00	0.00	0.00	XXX
92534		B	Optokinetic nystagmus test	0.00	0.00	0.00	0.00	XXX
92541		A	Spontaneous nystagmus test	0.40	1.34	NA	0.02	XXX
92541	TC	A	Spontaneous nystagmus test	0.00	1.18	NA	0.00	XXX
92541	26	A	Spontaneous nystagmus test	0.40	0.16	0.16	0.02	XXX
92542		A	Positional nystagmus test	0.33	1.52	NA	0.02	XXX
92542	TC	A	Positional nystagmus test	0.00	1.38	NA	0.00	XXX
92542	26	A	Positional nystagmus test	0.33	0.13	0.13	0.01	XXX
92543		A	Caloric vestibular test	0.10	0.75	NA	0.00	XXX
92543	TC	A	Caloric vestibular test	0.00	0.71	NA	0.00	XXX
92543	26	A	Caloric vestibular test	0.10	0.04	0.04	0.00	XXX
92544		A	Optokinetic nystagmus test	0.26	1.22	NA	0.01	XXX
92544	TC	A	Optokinetic nystagmus test	0.00	1.12	NA	0.00	XXX
92544	26	A	Optokinetic nystagmus test	0.26	0.11	0.11	0.01	XXX
92545		A	Oscillating tracking test	0.23	1.21	NA	0.01	XXX
92545	TC	A	Oscillating tracking test	0.00	1.11	NA	0.00	XXX
92545	26	A	Oscillating tracking test	0.23	0.09	0.09	0.01	XXX
92546		A	Sinusoidal rotational test	0.29	2.17	NA	0.01	XXX
92546	TC	A	Sinusoidal rotational test	0.00	2.06	NA	0.00	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
92546	26	A	Sinusoidal rotational test	0.29	0.11	0.11	0.01	XXX
92547		A	Supplemental electrical test	0.00	0.12	0.12	0.00	ZZZ
92548		A	Posturography	0.50	2.12	NA	0.02	XXX
92548	TC	A	Posturography	0.00	1.93	NA	0.00	XXX
92548	26	A	Posturography	0.50	0.19	0.19	0.02	XXX
92551		N	Pure tone hearing test, air	0.00	0.27	NA	0.00	XXX
92552		A	Pure tone audiometry, air	0.00	0.65	NA	0.00	XXX
92553		A	Audiometry, air & bone	0.00	0.79	NA	0.00	XXX
92555		A	Speech threshold audiometry	0.00	0.43	NA	0.00	XXX
92556		A	Speech audiometry, complete	0.00	0.68	NA	0.00	XXX
92557		A	Comprehensive hearing test	0.60	0.35	0.25	0.02	XXX
92561		A	Bekesy audiometry, diagnosis	0.00	0.86	NA	0.00	XXX
92562		A	Loudness balance test	0.00	0.82	NA	0.00	XXX
92563		A	Tone decay hearing test	0.00	0.62	NA	0.00	XXX
92564		A	Sisi hearing test	0.00	0.59	NA	0.00	XXX
92565		A	Stenger test, pure tone	0.00	0.31	NA	0.00	XXX
92567		A	Tympanometry	0.20	0.15	0.08	0.01	XXX
92568		A	Acoustic refl threshold tst	0.29	0.12	0.12	0.01	XXX
92569		A	Acoustic reflex decay test	0.20	0.08	0.08	0.01	XXX
92571		A	Filtered speech hearing test	0.00	0.46	NA	0.00	XXX
92572		A	Staggered spondaic word test	0.00	0.88	NA	0.00	XXX
92575		A	Sensorineural acuity test	0.00	1.23	NA	0.00	XXX
92576		A	Synthetic sentence test	0.00	0.63	NA	0.00	XXX
92577		A	Stenger test, speech	0.00	0.32	NA	0.00	XXX
92579		A	Visual audiometry (vra)	0.70	0.49	0.33	0.03	XXX
92582		A	Conditioning play audiometry	0.00	1.26	NA	0.00	XXX
92583		A	Select picture audiometry	0.00	0.88	NA	0.00	XXX
92584		A	Electrocochleography	0.00	1.48	NA	0.00	XXX
92585		A	Auditor evoke potent, compre	0.50	2.43	NA	0.02	XXX
92585	TC	A	Auditor evoke potent, compre	0.00	2.22	NA	0.00	XXX
92585	26	A	Auditor evoke potent, compre	0.50	0.21	0.21	0.02	XXX
92586		A	Auditor evoke potent, limit	0.00	1.70	NA	0.00	XXX
92587		A	Evoked auditory test	0.13	0.71	NA	0.01	XXX
92587	TC	A	Evoked auditory test	0.00	0.65	NA	0.00	XXX
92587	26	A	Evoked auditory test	0.13	0.05	0.05	0.01	XXX
92588		A	Evoked auditory test	0.36	1.24	NA	0.01	XXX
92588	TC	A	Evoked auditory test	0.00	1.09	NA	0.00	XXX
92588	26	A	Evoked auditory test	0.36	0.15	0.15	0.01	XXX
92596		A	Ear protector evaluation	0.00	1.13	NA	0.00	XXX
92597		A	Oral speech device eval	0.86	2.12	0.40	0.04	XXX
92601		A	Cochlear implt f/up exam < 7	2.30	1.49	1.00	0.09	XXX
92602		A	Reprogram cochlear implt < 7	1.30	0.94	0.40	0.05	XXX
92603		A	Cochlear implt f/up exam 7 >	2.25	1.40	0.92	0.09	XXX
92604		A	Reprogram cochlear implt 7 >	1.25	0.90	0.51	0.05	XXX
92605		B	Eval for nonspeech device rx	0.00	5.85	NA	0.00	XXX
92606		B	Non-speech device service	0.00	2.03	NA	0.00	XXX
92607		A	Ex for speech device rx, 1hr	0.00	4.70	NA	0.00	XXX
92608		A	Ex for speech device rx addl	0.00	1.22	NA	0.00	XXX
92609		A	Use of speech device service	0.00	2.73	NA	0.00	XXX
92610		A	Evaluate swallowing function	0.00	1.79	NA	0.00	XXX
92611		A	Motion fluoroscopy/swallow	0.00	2.13	NA	0.00	XXX
92612		A	Endoscopy swallow tst (fees)	1.27	3.12	0.59	0.05	XXX
92613		A	Endoscopy swallow tst (fees)	0.71	0.32	0.32	0.03	XXX
92614		A	Laryngoscopic sensory test	1.27	2.68	0.61	0.05	XXX
92615		A	Eval laryngoscopy sense tst	0.63	0.30	0.29	0.03	XXX
92616		A	Fees w/laryngeal sense test	1.88	3.35	0.84	0.08	XXX
92617		A	Interprt fees/laryngeal test	0.79	0.35	0.35	0.03	XXX
92620		A	Auditory function, 60 min	1.50	0.93	0.71	0.05	XXX
92621		A	Auditory function, + 15 min	0.35	0.18	0.11	0.01	ZZZ
92625		A	Tinnitus assessment	1.15	0.61	0.46	0.05	XXX
92626		A	Eval aud rehab status	1.40	0.77	0.51	0.06	XXX
92627		A	Eval aud status rehab add-on	0.33	0.21	0.13	0.01	ZZZ
92630		I	Aud rehab pre-ling hear loss	0.00	1.29	NA	0.00	XXX
92633		I	Aud rehab postling hear loss	0.00	1.35	NA	0.00	XXX
92640		A	Aud brainstem implt programg	1.76	0.98	0.65	0.29	XXX
92700		C	Ent procedure/service	0.00	0.00	0.00	0.00	XXX
92950		A	Heart/lung resuscitation cpr	3.79	3.55	0.88	0.23	000
92953		A	Temporary external pacing	0.23	NA	0.06	0.01	000
92960		A	Cardioversion electric, ext	2.25	3.18	0.98	0.12	000
92961		A	Cardioversion, electric, int	4.59	NA	1.77	0.35	000
92970		A	Cardioassist, internal	3.51	NA	1.17	0.18	000
92971		A	Cardioassist, external	1.77	NA	0.71	0.09	000
92973		A	Percut coronary thrombectomy	3.28	NA	1.10	0.17	ZZZ
92974		A	Cath place, cardio brachytx	3.00	NA	1.01	0.17	ZZZ
92975		A	Dissolve clot, heart vessel	7.24	NA	2.47	0.38	000
92977		A	Dissolve clot, heart vessel	0.00	1.27	NA	0.00	XXX
92978		C	Intravasc us, heart add-on	0.00	NA	NA	0.00	ZZZ
92978	TC	C	Intravasc us, heart add-on	0.00	NA	NA	0.00	ZZZ
92978	26	A	Intravasc us, heart add-on	1.80	0.60	0.60	0.10	ZZZ
92979		C	Intravasc us, heart add-on	0.00	NA	NA	0.00	ZZZ
92979	TC	C	Intravasc us, heart add-on	0.00	NA	NA	0.00	ZZZ
92979	26	A	Intravasc us, heart add-on	1.44	0.48	0.48	0.08	ZZZ
92980		A	Insert intracoronary stent	14.82	NA	5.14	0.77	000
92981		A	Insert intracoronary stent	4.16	NA	1.40	0.22	ZZZ

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CPT[1,7]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
92982		A	Coronary artery dilation	10.96	NA	3.84	0.57	000
92984		A	Coronary artery dilation	2.97	NA	1.00	0.15	ZZZ
92986		A	Revision of aortic valve	22.70	NA	10.06	1.22	090
92987		A	Revision of mitral valve	23.48	NA	10.36	1.19	090
92990		A	Revision of pulmonary valve	18.12	NA	8.40	0.92	090
92992		C	Revision of heart chamber	0.00	0.00	0.00	0.00	090
92993		C	Revision of heart chamber	0.00	0.00	0.00	0.00	090
92995		A	Coronary atherectomy	12.07	NA	4.21	0.62	000
92996		A	Coronary atherectomy add-on	3.26	NA	1.09	0.17	ZZZ
92997		A	Pul art balloon repr, percut	11.98	NA	4.16	0.61	000
92998		A	Pul art balloon repr, percut	5.99	NA	2.00	0.31	ZZZ
93000		A	Electrocardiogram, complete	0.17	0.28	0.28	0.01	XXX
93005		A	Electrocardiogram, tracing	0.00	0.22	NA	0.00	XXX
93010		A	Electrocardiogram report	0.17	0.06	0.06	0.01	XXX
93012		A	Transmission of ecg	0.00	3.60	NA	0.00	XXX
93014		A	Report on transmitted ecg	0.52	0.18	0.18	0.03	XXX
93015		A	Cardiovascular stress test	0.75	1.39	1.39	0.04	XXX
93016		A	Cardiovascular stress test	0.45	0.15	0.15	0.02	XXX
93017		A	Cardiovascular stress test	0.00	1.13	NA	0.00	XXX
93018		A	Cardiovascular stress test	0.30	0.10	0.10	0.01	XXX
93024		A	Cardiac drug stress test	1.17	1.71	NA	0.06	XXX
93024	TC	A	Cardiac drug stress test	0.00	1.31	NA	0.00	XXX
93024	26	A	Cardiac drug stress test	1.17	0.40	0.40	0.06	XXX
93025		A	Microvolt t-wave assess	0.75	3.22	NA	0.04	XXX
93025	TC	A	Microvolt t-wave assess	0.00	2.97	NA	0.00	XXX
93025	26	A	Microvolt t-wave assess	0.75	0.25	0.25	0.04	XXX
93040		A	Rhythm ECG with report	0.16	0.17	0.17	0.01	XXX
93041		A	Rhythm ECG, tracing	0.00	0.13	NA	0.00	XXX
93042		A	Rhythm ECG, report	0.16	0.04	0.04	0.01	XXX
93224		A	ECG monitor/report, 24 hrs	0.52	1.45	1.45	0.03	XXX
93225		A	ECG monitor/record, 24 hrs	0.00	0.63	NA	0.00	XXX
93226		A	ECG monitor/report, 24 hrs	0.00	0.89	NA	0.00	XXX
93227		A	ECG monitor/review, 24 hrs	0.52	0.21	0.21	0.03	XXX
93228		A	Remote 30 day ecg rev/report	0.52	0.19	0.19	0.03	XXX
93229		C	Remote 30 day ecg tech supp	0.00	0.00	NA	0.00	XXX
93230		A	ECG monitor/report, 24 hrs	0.52	1.35	1.35	0.03	XXX
93231		A	Ecg monitor/record, 24 hrs	0.00	0.55	NA	0.00	XXX
93232		A	ECG monitor/report, 24 hrs	0.00	1.04	NA	0.00	XXX
93233		A	ECG monitor/review, 24 hrs	0.52	0.18	0.18	0.02	XXX
93235		C	ECG monitor/report, 24 hrs	0.00	0.00	0.00	0.00	XXX
93236		C	ECG monitor/report, 24 hrs	0.00	0.00	NA	0.00	XXX
93237		A	ECG monitor/review, 24 hrs	0.45	0.15	0.15	0.02	XXX

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CPT[1,7]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
93268		A	ECG record/review	0.52	0.58	0.58	0.03	XXX
93270		A	ECG recording	0.00	0.21	NA	0.00	XXX
93271		A	Ecg/monitorng and analysis	0.00	4.59	NA	0.00	XXX
93272		A	Ecg/review, interpret only	0.52	0.17	0.17	0.03	XXX
93278		A	ECG/signal-averaged	0.25	0.52	NA	0.01	XXX
93278	TC	A	ECG/signal-averaged	0.00	0.43	NA	0.00	XXX
93278	26	A	ECG/signal-averaged	0.25	0.09	0.09	0.01	XXX
93279		A	Pm device progr eval, sngl	0.65	0.62	NA	0.03	XXX
93279	TC	A	Pm device progr eval, sngl	0.00	0.40	NA	0.00	XXX
93279	26	A	Pm device progr eval, sngl	0.65	0.22	0.22	0.03	XXX
93280		A	Pm device progr eval, dual	0.77	0.71	NA	0.04	XXX
93280	TC	A	Pm device progr eval, dual	0.00	0.45	NA	0.00	XXX
93280	26	A	Pm device progr eval, dual	0.77	0.26	0.26	0.04	XXX
93281		A	Pm device progr eval, multi	0.90	0.83	NA	0.05	XXX
93281	TC	A	Pm device progr eval, multi	0.00	0.52	NA	0.00	XXX
93281	26	A	Pm device progr eval, multi	0.90	0.31	0.31	0.05	XXX
93282		A	Icd device prog eval, 1 sngl	0.85	0.74	NA	0.04	XXX
93282	TC	A	Icd device prog eval, 1 sngl	0.00	0.46	NA	0.00	XXX
93282	26	A	Icd device prog eval, 1 sngl	0.85	0.29	0.29	0.04	XXX
93283		A	Icd device progr eval, dual	1.05	0.89	NA	0.05	XXX
93283	TC	A	Icd device progr eval, dual	0.00	0.53	NA	0.00	XXX
93283	26	A	Icd device progr eval, dual	1.05	0.36	0.36	0.05	XXX
93284		A	Icd device progr eval, mult	1.25	1.03	NA	0.07	XXX
93284	TC	A	Icd device progr eval, mult	0.00	0.61	NA	0.00	XXX
93284	26	A	Icd device progr eval, mult	1.25	0.42	0.42	0.06	XXX
93285		A	Ilr device eval progr	0.52	0.53	NA	0.03	XXX
93285	TC	A	Ilr device eval progr	0.00	0.36	NA	0.00	XXX
93285	26	A	Ilr device eval progr	0.52	0.18	0.18	0.03	XXX
93286		A	Pre-op pm device eval	0.30	0.42	NA	0.02	XXX
93286	TC	A	Pre-op pm device eval	0.00	0.31	NA	0.00	XXX
93286	26	A	Pre-op pm device eval	0.30	0.11	0.11	0.02	XXX
93287		A	Pre-op icd device eval	0.45	0.51	NA	0.02	XXX
93287	TC	A	Pre-op icd device eval	0.00	0.34	NA	0.00	XXX
93287	26	A	Pre-op icd device eval	0.45	0.16	0.16	0.02	XXX
93288		A	Pm device eval in person	0.43	0.51	NA	0.02	XXX
93288	TC	A	Pm device eval in person	0.00	0.36	NA	0.00	XXX
93288	26	A	Pm device eval in person	0.43	0.15	0.15	0.02	XXX
93289		A	Icd device interrogate	0.78	0.71	NA	0.04	XXX
93289	TC	A	Icd device interrogate	0.00	0.44	NA	0.00	XXX
93289	26	A	Icd device interrogate	0.78	0.26	0.26	0.04	XXX
93290		A	Icm device eval	0.43	0.41	NA	0.02	XXX
93290	TC	A	Icm device eval	0.00	0.26	NA	0.00	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
93290	26	A	Icm device eval	0.43	0.16	0.16	0.02	XXX
93291		A	Ilr device interrogate	0.43	0.48	NA	0.02	XXX
93291	TC	A	Ilr device interrogate	0.00	0.33	NA	0.00	XXX
93291	26	A	Ilr device interrogate	0.43	0.15	0.15	0.02	XXX
93292		A	Wcd device interrogate	0.43	0.39	NA	0.02	XXX
93292	TC	A	Wcd device interrogate	0.00	0.25	NA	0.00	XXX
93292	26	A	Wcd device interrogate	0.43	0.15	0.15	0.02	XXX
93293		A	Pm phone r-strip device eval	0.32	1.01	NA	0.02	XXX
93293	TC	A	Pm phone r-strip device eval	0.00	0.91	NA	0.00	XXX
93293	26	A	Pm phone r-strip device eval	0.32	0.11	0.11	0.02	XXX
93294		A	Pm device interrogate remote	0.65	0.22	0.22	0.03	XXX
93295		A	Icd device interrogat remote	1.17	0.40	0.40	0.06	XXX
93296		A	Pm/icd remote tech serv	0.00	0.72	NA	0.00	XXX
93297		A	Icm device interrogat remote	0.52	0.19	0.19	0.03	XXX
93298		A	Ilr device interrogat remote	0.52	0.18	0.18	0.03	XXX
93299		C	Icm/ilr remote tech serv	0.00	0.00	NA	0.00	XXX
93303		A	Echo transthoracic	1.30	3.62	NA	0.06	XXX
93303	TC	A	Echo transthoracic	0.00	3.18	NA	0.00	XXX
93303	26	A	Echo transthoracic	1.30	0.44	0.44	0.06	XXX
93304		A	Echo transthoracic	0.75	2.52	NA	0.04	XXX
93304	TC	A	Echo transthoracic	0.00	2.27	NA	0.00	XXX
93304	26	A	Echo transthoracic	0.75	0.25	0.25	0.04	XXX
93306		A	Tte w/doppler, complete	1.30	2.94	NA	0.07	XXX
93306	TC	A	Tte w/doppler, complete	0.00	2.49	NA	0.00	XXX
93306	26	A	Tte w/doppler, complete	1.30	0.44	0.44	0.06	XXX
93307		A	Tte w/o doppler, complete	0.92	2.76	NA	0.05	XXX
93307	TC	A	Tte w/o doppler, complete	0.00	2.45	NA	0.00	XXX
93307	26	A	Tte w/o doppler, complete	0.92	0.31	0.31	0.04	XXX
93308		A	Tte, f-up or lmtd	0.53	1.90	NA	0.03	XXX
93308	TC	A	Tte, f-up or lmtd	0.00	1.72	NA	0.00	XXX
93308	26	A	Tte, f-up or lmtd	0.53	0.18	0.18	0.03	XXX
93312		A	Echo transesophageal	2.20	5.72	NA	0.11	XXX
93312	TC	A	Echo transesophageal	0.00	5.05	NA	0.01	XXX
93312	26	A	Echo transesophageal	2.20	0.66	0.66	0.11	XXX
93313		A	Echo transesophageal	0.95	NA	0.17	0.06	XXX
93314		A	Echo transesophageal	1.25	5.82	NA	0.06	XXX
93314	TC	A	Echo transesophageal	0.00	5.42	NA	0.00	XXX
93314	26	A	Echo transesophageal	1.25	0.40	0.40	0.06	XXX
93315		C	Echo transesophageal	0.00	NA	NA	0.00	XXX
93315	TC	C	Echo transesophageal	0.00	NA	NA	0.00	XXX
93315	26	A	Echo transesophageal	2.78	0.89	0.89	0.17	XXX
93316		A	Echo transesophageal	0.95	NA	0.22	0.05	XXX

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93317		C	Echo transesophageal	0.00	NA	NA	0.00	XXX
93317	TC	C	Echo transesophageal	0.00	NA	NA	0.00	XXX
93317	26	A	Echo transesophageal	1.83	0.60	0.60	0.19	XXX
93318		C	Echo transesophageal intraop	0.00	NA	NA	0.00	XXX
93318	TC	C	Echo transesophageal intraop	0.00	NA	NA	0.00	XXX
93318	26	A	Echo transesophageal intraop	2.20	0.68	0.68	0.23	XXX
93320		A	Doppler echo exam, heart	0.38	1.23	1.23	0.02	ZZZ
93320	TC	A	Doppler echo exam, heart	0.00	1.10	1.10	0.00	ZZZ
93320	26	A	Doppler echo exam, heart	0.38	0.13	0.13	0.02	ZZZ
93321		A	Doppler echo exam, heart	0.15	0.45	0.45	0.01	ZZZ
93321	TC	A	Doppler echo exam, heart	0.00	0.40	0.40	0.00	ZZZ
93321	26	A	Doppler echo exam, heart	0.15	0.05	0.05	0.01	ZZZ
93325		A	Doppler color flow add-on	0.07	0.50	0.50	0.00	ZZZ
93325	TC	A	Doppler color flow add-on	0.00	0.47	0.47	0.00	ZZZ
93325	26	A	Doppler color flow add-on	0.07	0.02	0.02	0.00	ZZZ
93350		A	Stress tte only	1.46	3.68	NA	0.07	XXX
93350	TC	A	Stress tte only	0.00	3.18	NA	0.00	XXX
93350	26	A	Stress tte only	1.46	0.50	0.50	0.07	XXX
93351		A	Stress tte complete	1.75	4.18	NA	0.09	XXX
93351	TC	A	Stress tte complete	0.00	3.59	NA	0.16	XXX
93351	26	A	Stress tte complete	1.75	0.59	NA	0.06	XXX
93352		A	Admin ecg contrast agent	0.19	0.63	NA	0.01	ZZZ
93501		A	Right heart catheterization	3.02	11.37	NA	0.16	000
93501	TC	A	Right heart catheterization	0.00	10.36	NA	0.01	000
93501	26	A	Right heart catheterization	3.02	1.01	1.01	0.15	000
93503		A	Insert/place heart catheter	2.91	NA	NA	0.19	000
93505		A	Biopsy of heart lining	4.37	11.06	NA	0.32	000
93505	TC	A	Biopsy of heart lining	0.00	9.58	NA	0.01	000
93505	26	A	Biopsy of heart lining	4.37	1.47	1.47	0.31	000
93508		A	Cath placement, angiography	4.09	15.55	NA	0.21	000
93508	TC	A	Cath placement, angiography	0.00	14.17	NA	0.01	000
93508	26	A	Cath placement, angiography	4.09	1.37	1.37	0.20	000
93510		A	Left heart catheterization	4.32	15.24	NA	0.22	000
93510	TC	A	Left heart catheterization	0.00	13.79	NA	0.01	000
93510	26	A	Left heart catheterization	4.32	1.45	1.45	0.21	000
93511		C	Left heart catheterization	0.00	NA	NA	0.00	000
93511	TC	C	Left heart catheterization	0.00	NA	NA	0.00	000
93511	26	A	Left heart catheterization	5.02	1.68	1.68	0.26	000
93514		C	Left heart catheterization	0.00	NA	NA	0.00	000
93514	TC	C	Left heart catheterization	0.00	NA	NA	0.00	000
93514	26	A	Left heart catheterization	7.04	2.36	2.36	0.36	000
93524		C	Left heart catheterization	0.00	NA	NA	0.00	000

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
93524	TC	C	Left heart catheterization	0.00	NA	NA	0.00	000
93524	26	A	Left heart catheterization	6.94	2.35	2.35	0.35	000
93526		A	Rt & Lt heart catheters	5.98	19.20	NA	0.31	000
93526	TC	A	Rt & Lt heart catheters	0.00	17.20	NA	0.02	000
93526	26	A	Rt & Lt heart catheters	5.98	2.01	2.01	0.29	000
93527		C	Rt & Lt heart catheters	0.00	NA	NA	0.00	000
93527	TC	C	Rt & Lt heart catheters	0.00	NA	NA	0.00	000
93527	26	A	Rt & Lt heart catheters	7.27	2.44	2.44	0.38	000
93528		C	Rt & Lt heart catheters	0.00	NA	NA	0.00	000
93528	TC	C	Rt & Lt heart catheters	0.00	NA	NA	0.00	000
93528	26	A	Rt & Lt heart catheters	8.99	3.10	3.10	0.46	000
93529		C	Rt, lt heart catheterization	0.00	NA	NA	0.00	000
93529	TC	C	Rt, lt heart catheterization	0.00	NA	NA	0.00	000
93529	26	A	Rt, lt heart catheterization	4.79	1.64	1.64	0.25	000
93530		C	Rt heart cath, congenital	0.00	NA	NA	0.00	000
93530	TC	C	Rt heart cath, congenital	0.00	NA	NA	0.00	000
93530	26	A	Rt heart cath, congenital	4.22	1.43	1.43	0.25	000
93531		C	R & l heart cath, congenital	0.00	NA	NA	0.00	000
93531	TC	C	R & l heart cath, congenital	0.00	NA	NA	0.00	000
93531	26	A	R & l heart cath, congenital	8.34	2.80	2.80	0.42	000
93532		C	R & l heart cath, congenital	0.00	NA	NA	0.00	000
93532	TC	C	R & l heart cath, congenital	0.00	NA	NA	0.00	000
93532	26	A	R & l heart cath, congenital	9.99	3.36	3.36	0.51	000
93533		C	R & l heart cath, congenital	0.00	NA	NA	0.00	000
93533	TC	C	R & l heart cath, congenital	0.00	NA	NA	0.00	000
93533	26	A	R & l heart cath, congenital	6.69	2.23	2.23	0.34	000
93539		A	Injection, cardiac cath	0.40	1.20	0.13	0.02	000
93540		A	Injection, cardiac cath	0.43	3.95	0.14	0.02	000
93541		A	Injection for lung angiogram	0.29	0.10	0.10	0.01	000
93542		A	Injection for heart x-rays	0.29	2.41	0.10	0.02	000
93543		A	Injection for heart x-rays	0.29	1.26	0.10	0.01	000
93544		A	Injection for aortography	0.25	1.05	0.08	0.01	000
93545		A	Inject for coronary x-rays	0.40	2.82	0.13	0.02	000
93555		A	Imaging, cardiac cath	0.81	0.39	NA	0.04	XXX
93555	TC	A	Imaging, cardiac cath	0.00	0.11	NA	0.00	XXX
93555	26	A	Imaging, cardiac cath	0.81	0.27	0.27	0.04	XXX
93556		A	Imaging, cardiac cath	0.83	0.57	NA	0.04	XXX
93556	TC	A	Imaging, cardiac cath	0.00	0.29	NA	0.00	XXX
93556	26	A	Imaging, cardiac cath	0.83	0.28	0.28	0.04	XXX
93561		C	Cardiac output measurement	0.00	NA	NA	0.00	000
93561	TC	C	Cardiac output measurement	0.00	NA	NA	0.00	000
93561	26	A	Cardiac output measurement	0.50	0.16	0.16	0.03	000

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
93562		C	Cardiac output measurement	0.00	NA	NA	0.00	000
93562	TC	C	Cardiac output measurement	0.00	NA	NA	0.00	000
93562	26	A	Cardiac output measurement	0.16	0.04	0.04	0.01	000
93571		C	Heart flow reserve measure	0.00	NA	NA	0.00	ZZZ
93571	TC	C	Heart flow reserve measure	0.00	NA	NA	0.00	ZZZ
93571	26	A	Heart flow reserve measure	1.80	0.61	0.61	0.10	ZZZ
93572		C	Heart flow reserve measure	0.00	NA	NA	0.00	ZZZ
93572	TC	C	Heart flow reserve measure	0.00	NA	NA	0.00	ZZZ
93572	26	A	Heart flow reserve measure	1.44	0.48	0.48	0.09	ZZZ
93580		A	Transcath closure of asd	17.97	NA	6.35	0.94	000
93581		A	Transcath closure of vsd	24.39	NA	8.47	1.24	000
93600		C	Bundle of His recording	0.00	NA	NA	0.00	000
93600	TC	C	Bundle of His recording	0.00	NA	NA	0.00	000
93600	26	A	Bundle of His recording	2.12	0.71	0.71	0.12	000
93602		C	Intra-atrial recording	0.00	NA	NA	0.00	000
93602	TC	C	Intra-atrial recording	0.00	NA	NA	0.00	000
93602	26	A	Intra-atrial recording	2.12	0.71	0.71	0.14	000
93603		C	Right ventricular recording	0.00	NA	NA	0.00	000
93603	TC	C	Right ventricular recording	0.00	NA	NA	0.00	000
93603	26	A	Right ventricular recording	2.12	0.70	0.70	0.15	000
93609		C	Map tachycardia, add-on	0.00	NA	NA	0.00	ZZZ
93609	TC	C	Map tachycardia, add-on	0.00	NA	NA	0.00	ZZZ
93609	26	A	Map tachycardia, add-on	4.99	1.68	1.68	0.26	ZZZ
93610		C	Intra-atrial pacing	0.00	NA	NA	0.00	000
93610	TC	C	Intra-atrial pacing	0.00	NA	NA	0.00	000
93610	26	A	Intra-atrial pacing	3.02	1.00	1.00	0.21	000
93612		C	Intraventricular pacing	0.00	NA	NA	0.00	000
93612	TC	C	Intraventricular pacing	0.00	NA	NA	0.00	000
93612	26	A	Intraventricular pacing	3.02	0.99	0.99	0.22	000
93613		A	Electrophys map 3d, add-on	6.99	NA	2.35	0.37	ZZZ
93615		C	Esophageal recording	0.00	NA	NA	0.00	000
93615	TC	C	Esophageal recording	0.00	NA	NA	0.00	000
93615	26	A	Esophageal recording	0.99	0.33	0.33	0.05	000
93616		C	Esophageal recording	0.00	NA	0.00	0.00	000
93616	TC	C	Esophageal recording	0.00	NA	0.00	0.00	000
93616	26	A	Esophageal recording	1.49	0.24	0.24	0.09	000
93618		C	Heart rhythm pacing	0.00	NA	NA	0.00	000
93618	TC	C	Heart rhythm pacing	0.00	NA	NA	0.00	000
93618	26	A	Heart rhythm pacing	4.25	1.42	1.42	0.23	000
93619		C	Electrophysiology evaluation	0.00	NA	NA	0.00	000
93619	TC	C	Electrophysiology evaluation	0.00	NA	NA	0.00	000
93619	26	A	Electrophysiology evaluation	7.31	2.45	2.45	0.38	000

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
93620		C	Electrophysiology evaluation	0.00	NA	0.00	0.00	000
93620	TC	C	Electrophysiology evaluation	0.00	NA	0.00	0.00	000
93620	26	A	Electrophysiology evaluation	11.57	3.90	3.90	0.61	000
93621		C	Electrophysiology evaluation	0.00	NA	0.00	0.00	ZZZ
93621	TC	C	Electrophysiology evaluation	0.00	NA	0.00	0.00	ZZZ
93621	26	A	Electrophysiology evaluation	2.10	0.71	0.71	0.11	ZZZ
93622		C	Electrophysiology evaluation	0.00	NA	0.00	0.00	ZZZ
93622	TC	C	Electrophysiology evaluation	0.00	NA	0.00	0.00	ZZZ
93622	26	A	Electrophysiology evaluation	3.10	1.04	1.04	0.17	ZZZ
93623		C	Stimulation, pacing heart	0.00	NA	0.00	0.00	ZZZ
93623	TC	C	Stimulation, pacing heart	0.00	NA	0.00	0.00	ZZZ
93623	26	A	Stimulation, pacing heart	2.85	0.96	0.96	0.15	ZZZ
93624		C	Electrophysiologic study	0.00	NA	0.00	0.00	000
93624	TC	C	Electrophysiologic study	0.00	NA	0.00	0.00	000
93624	26	A	Electrophysiologic study	4.80	1.60	1.60	0.26	000
93631		C	Heart pacing, mapping	0.00	NA	0.00	0.00	000
93631	TC	C	Heart pacing, mapping	0.00	NA	0.00	0.00	000
93631	26	A	Heart pacing, mapping	7.59	2.41	2.41	1.19	000
93640		C	Evaluation heart device	0.00	NA	NA	0.00	000
93640	TC	C	Evaluation heart device	0.00	NA	NA	0.00	000
93640	26	A	Evaluation heart device	3.51	1.18	1.18	0.22	000
93641		C	Electrophysiology evaluation	0.00	NA	NA	0.00	000
93641	TC	C	Electrophysiology evaluation	0.00	NA	NA	0.00	000
93641	26	A	Electrophysiology evaluation	5.92	1.99	1.99	0.32	000
93642		A	Electrophysiology evaluation	4.88	4.99	4.99	0.24	000
93642	TC	A	Electrophysiology evaluation	0.00	3.34	3.34	0.01	000
93642	26	A	Electrophysiology evaluation	4.88	1.65	1.65	0.23	000
93650		A	Ablate heart dysrhythm focus	10.49	NA	3.77	0.55	000
93651		A	Ablate heart dysrhythm focus	16.23	NA	5.46	0.86	000
93652		A	Ablate heart dysrhythm focus	17.65	NA	5.96	0.94	000
93660		A	Tilt table evaluation	1.89	2.07	2.07	0.10	000
93660	TC	A	Tilt table evaluation	0.00	1.42	1.42	0.01	000
93660	26	A	Tilt table evaluation	1.89	0.64	0.64	0.10	000
93662		C	Intracardiac ecg (ice)	0.00	NA	0.00	0.00	ZZZ
93662	TC	C	Intracardiac ecg (ice)	0.00	NA	0.00	0.00	ZZZ
93662	26	A	Intracardiac ecg (ice)	2.80	0.94	0.94	0.15	ZZZ
93668		N	Peripheral vascular rehab	0.00	0.44	NA	0.00	XXX
93701		A	Bioimpedance, thoracic	0.17	0.63	NA	0.01	XXX
93701	TC	A	Bioimpedance, thoracic	0.00	0.57	NA	0.00	XXX
93701	26	A	Bioimpedance, thoracic	0.17	0.06	0.06	0.01	XXX
93720		A	Total body plethysmography	0.17	1.11	1.11	0.01	XXX
93721		A	Plethysmography tracing	0.00	0.97	NA	0.00	XXX

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93722		A	Plethysmography report	0.17	0.05	0.05	0.01	XXX
93724		A	Analyze pacemaker system	4.88	2.30	2.30	0.25	000
93724	TC	A	Analyze pacemaker system	0.00	0.63	0.63	0.01	000
93724	26	A	Analyze pacemaker system	4.88	1.67	1.67	0.24	000
93740		B	Temperature gradient studies	0.16	NA	NA	0.01	XXX
93740	TC	B	Temperature gradient studies	0.00	NA	NA	0.00	XXX
93740	26	B	Temperature gradient studies	0.16	0.06	0.06	0.01	XXX
93745		C	Set-up cardiovert-defibrill	0.00	0.00	NA	0.00	XXX
93745	TC	C	Set-up cardiovert-defibrill	0.00	0.00	NA	0.00	XXX
93745	26	C	Set-up cardiovert-defibrill	0.00	0.00	0.00	0.00	XXX
93770		B	Measure venous pressure	0.16	NA	NA	0.01	XXX
93770	TC	B	Measure venous pressure	0.00	NA	NA	0.00	XXX
93770	26	B	Measure venous pressure	0.16	0.06	0.06	0.01	XXX
93784		A	Ambulatory BP monitoring	0.38	0.97	0.97	0.02	XXX
93786		A	Ambulatory BP recording	0.00	0.72	NA	0.00	XXX
93788		A	Ambulatory BP analysis	0.00	0.40	NA	0.00	XXX
93790		A	Review/report BP recording	0.38	0.14	0.14	0.02	XXX
93797		A	Cardiac rehab	0.18	0.27	0.07	0.01	000
93798		A	Cardiac rehab/monitor	0.28	0.35	0.10	0.01	000
93799		C	Cardiovascular procedure	0.00	0.00	NA	0.00	XXX
93799	TC	C	Cardiovascular procedure	0.00	0.00	NA	0.00	XXX
93799	26	C	Cardiovascular procedure	0.00	0.00	0.00	0.00	XXX
93875		A	Extracranial study	0.22	2.42	NA	0.01	XXX
93875	TC	A	Extracranial study	0.00	2.34	NA	0.00	XXX
93875	26	A	Extracranial study	0.22	0.08	0.08	0.01	XXX
93880		A	Extracranial study	0.60	5.49	NA	0.05	XXX
93880	TC	A	Extracranial study	0.00	5.30	NA	0.00	XXX
93880	26	A	Extracranial study	0.60	0.20	0.20	0.05	XXX
93882		A	Extracranial study	0.40	4.05	NA	0.05	XXX
93882	TC	A	Extracranial study	0.00	3.92	NA	0.00	XXX
93882	26	A	Extracranial study	0.40	0.13	0.13	0.05	XXX
93886		A	Intracranial study	0.94	8.06	NA	0.06	XXX
93886	TC	A	Intracranial study	0.00	7.71	NA	0.00	XXX
93886	26	A	Intracranial study	0.94	0.35	0.35	0.06	XXX
93888		A	Intracranial study	0.62	4.99	NA	0.05	XXX
93888	TC	A	Intracranial study	0.00	4.76	NA	0.00	XXX
93888	26	A	Intracranial study	0.62	0.22	0.22	0.05	XXX
93890		A	Tcd, vasoreactivity study	1.00	6.91	NA	0.06	XXX
93890	TC	A	Tcd, vasoreactivity study	0.00	6.54	NA	0.00	XXX
93890	26	A	Tcd, vasoreactivity study	1.00	0.37	0.37	0.05	XXX
93892		A	Tcd, emboli detect w/o inj	1.15	9.00	NA	0.07	XXX
93892	TC	A	Tcd, emboli detect w/o inj	0.00	8.56	NA	0.00	XXX

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93892	26	A	Tcd, emboli detect w/o inj	1.15	0.44	0.44	0.06	XXX
93893		A	Tcd, emboli detect w/inj	1.15	8.31	NA	0.07	XXX
93893	TC	A	Tcd, emboli detect w/inj	0.00	7.87	NA	0.00	XXX
93893	26	A	Tcd, emboli detect w/inj	1.15	0.44	0.44	0.07	XXX
93922		A	Extremity study	0.25	2.91	NA	0.02	XXX
93922	TC	A	Extremity study	0.00	2.82	NA	0.00	XXX
93922	26	A	Extremity study	0.25	0.08	0.08	0.02	XXX
93923		A	Extremity study	0.45	4.36	NA	0.05	XXX
93923	TC	A	Extremity study	0.00	4.21	NA	0.00	XXX
93923	26	A	Extremity study	0.45	0.14	0.14	0.05	XXX
93924		A	Extremity study	0.50	5.35	NA	0.05	XXX
93924	TC	A	Extremity study	0.00	5.19	NA	0.00	XXX
93924	26	A	Extremity study	0.50	0.16	0.16	0.05	XXX
93925		A	Lower extremity study	0.58	7.18	NA	0.05	XXX
93925	TC	A	Lower extremity study	0.00	6.99	NA	0.00	XXX
93925	26	A	Lower extremity study	0.58	0.19	0.19	0.05	XXX
93926		A	Lower extremity study	0.39	4.75	NA	0.06	XXX
93926	TC	A	Lower extremity study	0.00	4.64	NA	0.00	XXX
93926	26	A	Lower extremity study	0.39	0.12	0.12	0.06	XXX
93930		A	Upper extremity study	0.46	5.75	NA	0.04	XXX
93930	TC	A	Upper extremity study	0.00	5.60	NA	0.00	XXX
93930	26	A	Upper extremity study	0.46	0.15	0.15	0.04	XXX
93931		A	Upper extremity study	0.31	3.80	NA	0.03	XXX
93931	TC	A	Upper extremity study	0.00	3.70	NA	0.00	XXX
93931	26	A	Upper extremity study	0.31	0.10	0.10	0.03	XXX
93965		A	Extremity study	0.35	2.73	NA	0.03	XXX
93965	TC	A	Extremity study	0.00	2.62	NA	0.00	XXX
93965	26	A	Extremity study	0.35	0.11	0.11	0.03	XXX
93970		A	Extremity study	0.68	5.69	NA	0.07	XXX
93970	TC	A	Extremity study	0.00	5.48	NA	0.00	XXX
93970	26	A	Extremity study	0.68	0.21	0.21	0.07	XXX
93971		A	Extremity study	0.45	3.68	NA	0.05	XXX
93971	TC	A	Extremity study	0.00	3.55	NA	0.00	XXX
93971	26	A	Extremity study	0.45	0.14	0.14	0.05	XXX
93975		A	Vascular study	1.80	7.49	NA	0.16	XXX
93975	TC	A	Vascular study	0.00	6.92	NA	0.01	XXX
93975	26	A	Vascular study	1.80	0.57	0.57	0.15	XXX
93976		A	Vascular study	1.21	4.08	NA	0.10	XXX
93976	TC	A	Vascular study	0.00	3.70	NA	0.00	XXX
93976	26	A	Vascular study	1.21	0.37	0.37	0.09	XXX
93978		A	Vascular study	0.65	5.38	NA	0.07	XXX
93978	TC	A	Vascular study	0.00	5.17	NA	0.00	XXX
94002		A	Vent mgmt inpat, init day	1.99	NA	0.46	0.12	XXX
94003		A	Vent mgmt inpat, subq day	1.37	NA	0.40	0.08	XXX
94004		A	Vent mgmt nf per day	1.00	NA	0.29	0.06	XXX
94005		B	Home vent mgmt supervision	1.50	0.93	NA	0.08	XXX
94010		A	Breathing capacity test	0.17	0.71	NA	0.01	XXX
94010	TC	A	Breathing capacity test	0.00	0.65	NA	0.00	XXX
94010	26	A	Breathing capacity test	0.17	0.06	0.06	0.01	XXX
94014		A	Patient recorded spirometry	0.52	0.74	0.74	0.03	XXX
94015		A	Patient recorded spirometry	0.00	0.58	NA	0.00	XXX
94016		A	Review patient spirometry	0.52	0.17	0.17	0.02	XXX
94060		A	Evaluation of wheezing	0.31	1.22	1.22	0.02	XXX
94060	TC	A	Evaluation of wheezing	0.00	1.12	1.12	0.00	XXX
94060	26	A	Evaluation of wheezing	0.31	0.10	0.10	0.02	XXX
94070		A	Evaluation of wheezing	0.60	0.95	NA	0.03	XXX
94070	TC	A	Evaluation of wheezing	0.00	0.76	NA	0.00	XXX
94070	26	A	Evaluation of wheezing	0.60	0.19	0.19	0.03	XXX
94150		B	Vital capacity test	0.07	0.53	NA	0.00	XXX
94150	TC	B	Vital capacity test	0.00	0.50	NA	0.00	XXX
94150	26	B	Vital capacity test	0.07	0.03	0.03	0.00	XXX
94200		A	Lung function test (MBC/MVV)	0.11	0.49	NA	0.01	XXX
94200	TC	A	Lung function test (MBC/MVV)	0.00	0.45	NA	0.00	XXX
94200	26	A	Lung function test (MBC/MVV)	0.11	0.03	0.03	0.01	XXX
94240		A	Residual lung capacity	0.26	0.73	NA	0.01	XXX
94240	TC	A	Residual lung capacity	0.00	0.66	NA	0.00	XXX
94240	26	A	Residual lung capacity	0.26	0.08	0.08	0.01	XXX
94250		A	Expired gas collection	0.11	0.48	NA	0.01	XXX
94250	TC	A	Expired gas collection	0.00	0.45	NA	0.00	XXX
94250	26	A	Expired gas collection	0.11	0.03	0.03	0.01	XXX

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CPT[1,2] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
94260		A	Thoracic gas volume	0.13	0.66	NA	0.01	XXX
94260	TC	A	Thoracic gas volume	0.00	0.63	NA	0.00	XXX
94260	26	A	Thoracic gas volume	0.13	0.04	0.04	0.01	XXX
94350		A	Lung nitrogen washout curve	0.26	0.59	NA	0.01	XXX
94350	TC	A	Lung nitrogen washout curve	0.00	0.51	NA	0.00	XXX
94350	26	A	Lung nitrogen washout curve	0.26	0.08	0.08	0.01	XXX
94360		A	Measure airflow resistance	0.26	0.85	NA	0.01	XXX
94360	TC	A	Measure airflow resistance	0.00	0.77	NA	0.00	XXX
94360	26	A	Measure airflow resistance	0.26	0.08	0.08	0.01	XXX
94370		A	Breath airway closing volume	0.26	0.59	NA	0.01	XXX
94370	TC	A	Breath airway closing volume	0.00	0.50	NA	0.00	XXX
94370	26	A	Breath airway closing volume	0.26	0.08	0.08	0.01	XXX
94375		A	Respiratory flow volume loop	0.31	0.66	NA	0.02	XXX
94375	TC	A	Respiratory flow volume loop	0.00	0.57	NA	0.00	XXX
94375	26	A	Respiratory flow volume loop	0.31	0.10	0.10	0.02	XXX
94400		A	CO2 breathing response curve	0.40	0.97	NA	0.02	XXX
94400	TC	A	CO2 breathing response curve	0.00	0.85	NA	0.00	XXX
94400	26	A	CO2 breathing response curve	0.40	0.12	0.12	0.02	XXX
94450		A	Hypoxia response curve	0.40	1.37	NA	0.02	XXX
94450	TC	A	Hypoxia response curve	0.00	1.22	NA	0.00	XXX
94450	26	A	Hypoxia response curve	0.40	0.15	0.15	0.02	XXX
94452		A	Hast w/report	0.31	1.09	NA	0.02	XXX
94452	TC	A	Hast w/report	0.00	1.00	NA	0.00	XXX
94452	26	A	Hast w/report	0.31	0.09	0.09	0.02	XXX
94453		A	Hast w/oxygen titrate	0.40	1.51	NA	0.02	XXX
94453	TC	A	Hast w/oxygen titrate	0.00	1.40	NA	0.00	XXX
94453	26	A	Hast w/oxygen titrate	0.40	0.11	0.11	0.02	XXX
94610		A	Surfactant admin thru tube	1.16	0.46	0.46	0.06	XXX
94620		A	Pulmonary stress test/simple	0.64	0.76	NA	0.04	XXX
94620	TC	A	Pulmonary stress test/simple	0.00	0.57	NA	0.00	XXX
94620	26	A	Pulmonary stress test/simple	0.64	0.20	0.20	0.03	XXX
94621		A	Pulm stress test/complex	1.42	2.69	NA	0.07	XXX
94621	TC	A	Pulm stress test/complex	0.00	2.25	NA	0.00	XXX
94621	26	A	Pulm stress test/complex	1.42	0.44	0.44	0.07	XXX
94640		A	Airway inhalation treatment	0.00	0.42	NA	0.00	XXX
94642		C	Aerosol inhalation treatment	0.00	0.00	0.00	0.00	XXX
94644		A	Cbt, 1st hour	0.00	1.03	NA	0.00	XXX
94645		A	Cbt, each addl hour	0.00	0.33	NA	0.00	XXX
94660		A	Pos airway pressure, CPAP	0.76	0.81	0.24	0.04	XXX
94662		A	Neg press ventilation, cnp	0.76	NA	0.21	0.04	XXX
94664		A	Evaluate pt use of inhaler	0.00	0.40	NA	0.00	XXX
94667		A	Chest wall manipulation	0.00	0.55	NA	0.00	XXX
94668		A	Chest wall manipulation	0.00	0.54	NA	0.00	XXX
94680		A	Exhaled air analysis, o2	0.26	1.12	1.12	0.01	XXX
94680	TC	A	Exhaled air analysis, o2	0.00	1.03	1.03	0.00	XXX
94680	26	A	Exhaled air analysis, o2	0.26	0.09	0.09	0.01	XXX
94681		A	Exhaled air analysis, o2/co2	0.20	1.05	NA	0.01	XXX
94681	TC	A	Exhaled air analysis, o2/co2	0.00	0.98	NA	0.00	XXX
94681	26	A	Exhaled air analysis, o2/co2	0.20	0.07	0.07	0.01	XXX
94690		A	Exhaled air analysis	0.07	1.12	NA	0.00	XXX
94690	TC	A	Exhaled air analysis	0.00	1.09	NA	0.00	XXX
94690	26	A	Exhaled air analysis	0.07	0.03	0.03	0.00	XXX
94720		A	Monoxide diffusing capacity	0.26	1.01	NA	0.01	XXX
94720	TC	A	Monoxide diffusing capacity	0.00	0.94	NA	0.00	XXX
94720	26	A	Monoxide diffusing capacity	0.26	0.08	0.08	0.01	XXX
94725		A	Membrane diffusion capacity	0.26	0.96	NA	0.01	XXX
94725	TC	A	Membrane diffusion capacity	0.00	0.88	NA	0.00	XXX
94725	26	A	Membrane diffusion capacity	0.26	0.08	0.08	0.01	XXX
94750		A	Pulmonary compliance study	0.23	1.76	NA	0.01	XXX
94750	TC	A	Pulmonary compliance study	0.00	1.68	NA	0.00	XXX
94750	26	A	Pulmonary compliance study	0.23	0.07	0.07	0.01	XXX
94760		T	Measure blood oxygen level	0.00	0.07	NA	0.00	XXX
94761		T	Measure blood oxygen level	0.00	0.10	NA	0.00	XXX
94762		A	Measure blood oxygen level	0.00	0.67	NA	0.00	XXX
94770		A	Exhaled carbon dioxide test	0.15	NA	0.82	0.01	XXX
94770	TC	A	Exhaled carbon dioxide test	0.00	NA	0.77	0.00	XXX
94770	26	A	Exhaled carbon dioxide test	0.15	0.05	0.05	0.01	XXX
94772		C	Breath recording, infant	0.00	NA	NA	0.00	XXX
94772	TC	C	Breath recording, infant	0.00	NA	NA	0.00	XXX
94772	26	C	Breath recording, infant	0.00	0.00	0.00	0.00	XXX
94774		C	Ped home apnea rec, compl	0.00	0.00	0.00	0.00	YYY
94775		C	Ped home apnea rec, bk-up	0.00	0.00	0.00	0.00	YYY
94776		C	Ped home apnea rec, downld	0.00	0.00	0.00	0.00	YYY
94777		C	Ped home apnea rec, report	0.00	0.00	0.00	0.00	YYY
94799		C	Pulmonary service/procedure	0.00	0.00	NA	0.00	XXX
94799	TC	C	Pulmonary service/procedure	0.00	0.00	NA	0.00	XXX
94799	26	C	Pulmonary service/procedure	0.00	0.00	0.00	0.00	XXX
95004		A	Percut allergy skin tests	0.01	0.14	NA	0.00	XXX
95010		A	Percut allergy titrate test	0.15	0.32	NA	0.01	XXX
95012		A	Exhaled nitric oxide meas	0.00	0.48	NA	0.00	XXX
95015		A	Id allergy titrate-drug/bug	0.15	0.20	NA	0.01	XXX
95024		A	Id allergy test, drug/bug	0.01	0.16	NA	0.00	XXX
95027		A	Id allergy titrate-airborne	0.01	0.10	NA	0.00	XXX
95028		A	Id allergy test-delayed type	0.00	0.32	NA	0.00	XXX

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CPT[1,2]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
95044		A	Allergy patch tests	0.00	0.13	NA	0.00	XXX
95052		A	Photo patch test	0.00	0.14	NA	0.00	XXX
95056		A	Photosensitivity tests	0.00	1.05	NA	0.00	XXX
95060		A	Eye allergy tests	0.00	0.80	0.80	0.00	XXX
95065		A	Nose allergy test	0.00	0.61	0.61	0.00	XXX
95070		A	Bronchial allergy tests	0.00	0.69	NA	0.00	XXX
95071		A	Bronchial allergy tests	0.00	0.85	NA	0.00	XXX
95075		A	Ingestion challenge test	0.95	0.75	0.35	0.03	XXX
95115		A	Immunotherapy, one injection	0.00	0.22	NA	0.00	XXX
95117		A	Immunotherapy injections	0.00	0.26	NA	0.00	XXX
95120		I	Immunotherapy, one injection	0.00	0.00	0.00	0.00	XXX
95125		I	Immunotherapy, many antigens	0.00	0.00	0.00	0.00	XXX
95130		I	Immunotherapy, insect venom	0.00	0.00	0.00	0.00	XXX
95131		I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	XXX
95132		I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	XXX
95133		I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	XXX
95134		I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	XXX
95144		A	Antigen therapy services	0.06	0.25	0.02	0.00	XXX
95145		A	Antigen therapy services	0.06	0.32	0.02	0.00	XXX
95146		A	Antigen therapy services	0.06	0.60	0.02	0.00	XXX
95147		A	Antigen therapy services	0.06	0.59	0.02	0.00	XXX
95148		A	Antigen therapy services	0.06	0.87	0.02	0.00	XXX
95149		A	Antigen therapy services	0.06	1.16	0.02	0.00	XXX
95165		A	Antigen therapy services	0.06	0.26	0.02	0.00	XXX
95170		A	Antigen therapy services	0.06	0.18	0.02	0.00	XXX
95180		A	Rapid desensitization	2.01	1.62	0.83	0.06	XXX
95199		C	Allergy immunology services	0.00	0.00	0.00	0.00	XXX
95250		A	Glucose monitoring, cont	0.00	3.63	NA	0.00	XXX
95251		A	Gluc monitor, cont, phys i&r	0.85	0.35	0.35	0.04	XXX
95803		C	Actigraphy testing	0.00	0.00	NA	0.00	XXX
95803	TC	C	Actigraphy testing	0.00	0.00	NA	0.00	XXX
95803	26	C	Actigraphy testing	0.00	0.00	0.00	0.00	XXX
95805		A	Multiple sleep latency test	1.88	6.49	NA	0.10	XXX
95805	TC	A	Multiple sleep latency test	0.00	5.88	NA	0.01	XXX
95805	26	A	Multiple sleep latency test	1.88	0.61	0.61	0.10	XXX
95806		A	Sleep study, unattended	1.66	3.81	NA	0.09	XXX
95806	TC	A	Sleep study, unattended	0.00	3.25	NA	0.00	XXX
95806	26	A	Sleep study, unattended	1.66	0.56	0.56	0.08	XXX
95807		A	Sleep study, attended	1.66	9.76	NA	0.09	XXX
95807	TC	A	Sleep study, attended	0.00	9.23	NA	0.00	XXX
95807	26	A	Sleep study, attended	1.66	0.52	0.52	0.08	XXX
95808		A	Polysomnography, 1-3	2.65	16.69	NA	0.13	XXX

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CPT[1,2]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
95808	TC	A	Polysomnography, 1-3	0.00	15.78	NA	0.01	XXX
95808	26	A	Polysomnography, 1-3	2.65	0.91	0.91	0.12	XXX
95810		A	Polysomnography, 4 or more	3.52	16.27	NA	0.19	XXX
95810	TC	A	Polysomnography, 4 or more	0.00	15.13	NA	0.01	XXX
95810	26	A	Polysomnography, 4 or more	3.52	1.13	1.13	0.18	XXX
95811		A	Polysomnography w/cpap	3.79	18.01	NA	0.21	XXX
95811	TC	A	Polysomnography w/cpap	0.00	16.80	NA	0.01	XXX
95811	26	A	Polysomnography w/cpap	3.79	1.21	1.21	0.20	XXX
95812		A	Eeg, 41-60 minutes	1.08	8.58	NA	0.06	XXX
95812	TC	A	Eeg, 41-60 minutes	0.00	8.14	NA	0.00	XXX
95812	26	A	Eeg, 41-60 minutes	1.08	0.43	0.43	0.06	XXX
95813		A	Eeg, over 1 hour	1.73	9.22	NA	0.10	XXX
95813	TC	A	Eeg, over 1 hour	0.00	8.52	NA	0.00	XXX
95813	26	A	Eeg, over 1 hour	1.73	0.69	0.69	0.10	XXX
95816		A	Eeg, awake and drowsy	1.08	7.77	NA	0.07	XXX
95816	TC	A	Eeg, awake and drowsy	0.00	7.34	NA	0.00	XXX
95816	26	A	Eeg, awake and drowsy	1.08	0.43	0.43	0.06	XXX
95819		A	Eeg, awake and asleep	1.08	9.01	NA	0.06	XXX
95819	TC	A	Eeg, awake and asleep	0.00	8.57	NA	0.00	XXX
95819	26	A	Eeg, awake and asleep	1.08	0.43	0.43	0.06	XXX
95822		A	Eeg, coma or sleep only	1.08	8.10	NA	0.06	XXX
95822	TC	A	Eeg, coma or sleep only	0.00	7.66	NA	0.00	XXX
95822	26	A	Eeg, coma or sleep only	1.08	0.44	0.44	0.06	XXX
95824		C	Eeg, cerebral death only	0.00	NA	NA	0.00	XXX
95824	TC	C	Eeg, cerebral death only	0.00	NA	NA	0.00	XXX
95824	26	A	Eeg, cerebral death only	0.74	0.29	0.29	0.05	XXX
95827		A	Eeg, all night recording	1.08	17.56	NA	0.07	XXX
95827	TC	A	Eeg, all night recording	0.00	17.13	NA	0.00	XXX
95827	26	A	Eeg, all night recording	1.08	0.43	0.43	0.06	XXX
95829		A	Surgery electrocorticogram	6.20	36.81	NA	0.27	XXX
95829	TC	A	Surgery electrocorticogram	0.00	34.27	NA	0.02	XXX
95829	26	A	Surgery electrocorticogram	6.20	2.54	2.54	0.26	XXX
95830		A	Insert electrodes for EEG	1.70	3.87	0.65	0.11	XXX
95831		A	Limb muscle testing, manual	0.28	0.50	0.11	0.02	XXX
95832		A	Hand muscle testing, manual	0.29	0.48	0.13	0.03	XXX
95833		A	Body muscle testing, manual	0.47	0.51	0.13	0.01	XXX
95834		A	Body muscle testing, manual	0.60	0.67	0.20	0.02	XXX
95851		A	Range of motion measurements	0.16	0.31	0.05	0.01	XXX
95852		A	Range of motion measurements	0.11	0.29	0.04	0.01	XXX
95857		A	Tensilon test	0.53	0.80	0.24	0.03	XXX
95860		A	Muscle test, one limb	0.96	1.58	NA	0.05	XXX
95860	TC	A	Muscle test, one limb	0.00	1.16	NA	0.00	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
95860	26	A	Muscle test, one limb	0.96	0.42	0.42	0.05	XXX
95861		A	Muscle test, 2 limbs	1.54	2.23	NA	0.08	XXX
95861	TC	A	Muscle test, 2 limbs	0.00	1.57	NA	0.00	XXX
95861	26	A	Muscle test, 2 limbs	1.54	0.66	0.66	0.08	XXX
95863		A	Muscle test, 3 limbs	1.87	2.71	NA	0.11	XXX
95863	TC	A	Muscle test, 3 limbs	0.00	1.93	NA	0.01	XXX
95863	26	A	Muscle test, 3 limbs	1.87	0.78	0.78	0.10	XXX
95864		A	Muscle test, 4 limbs	1.99	2.90	NA	0.11	XXX
95864	TC	A	Muscle test, 4 limbs	0.00	2.07	NA	0.01	XXX
95864	26	A	Muscle test, 4 limbs	1.99	0.83	0.83	0.10	XXX
95865		A	Muscle test, larynx	1.57	1.70	NA	0.07	XXX
95865	TC	A	Muscle test, larynx	0.00	1.00	NA	0.00	XXX
95865	26	A	Muscle test, larynx	1.57	0.70	0.70	0.07	XXX
95866		A	Muscle test, hemidiaphragm	1.25	1.76	NA	0.08	XXX
95866	TC	A	Muscle test, hemidiaphragm	0.00	1.26	NA	0.00	XXX
95866	26	A	Muscle test, hemidiaphragm	1.25	0.50	0.50	0.07	XXX
95867		A	Muscle test cran nerv unilat	0.79	1.50	NA	0.04	XXX
95867	TC	A	Muscle test cran nerv unilat	0.00	1.16	NA	0.00	XXX
95867	26	A	Muscle test cran nerv unilat	0.79	0.34	0.34	0.04	XXX
95868		A	Muscle test cran nerve bilat	1.18	1.91	NA	0.06	XXX
95868	TC	A	Muscle test cran nerve bilat	0.00	1.42	NA	0.00	XXX
95868	26	A	Muscle test cran nerve bilat	1.18	0.50	0.50	0.06	XXX
95869		A	Muscle test, thor paraspinal	0.37	1.45	NA	0.02	XXX
95869	TC	A	Muscle test, thor paraspinal	0.00	1.29	NA	0.00	XXX
95869	26	A	Muscle test, thor paraspinal	0.37	0.16	0.16	0.02	XXX
95870		A	Muscle test, nonparaspinal	0.37	1.39	NA	0.02	XXX
95870	TC	A	Muscle test, nonparaspinal	0.00	1.23	NA	0.00	XXX
95870	26	A	Muscle test, nonparaspinal	0.37	0.16	0.16	0.02	XXX
95872		A	Muscle test, one fiber	2.88	2.22	NA	0.16	XXX
95872	TC	A	Muscle test, one fiber	0.00	1.05	NA	0.01	XXX
95872	26	A	Muscle test, one fiber	2.88	1.17	1.17	0.16	XXX
95873		A	Guide nerv destr, elec stim	0.37	1.39	1.39	0.01	ZZZ
95873	TC	A	Guide nerv destr, elec stim	0.00	1.21	1.21	0.00	ZZZ
95873	26	A	Guide nerv destr, elec stim	0.37	0.18	0.18	0.01	ZZZ
95874		A	Guide nerv destr, needle emg	0.37	1.31	1.31	0.02	ZZZ
95874	TC	A	Guide nerv destr, needle emg	0.00	1.15	1.15	0.00	ZZZ
95874	26	A	Guide nerv destr, needle emg	0.37	0.16	0.16	0.02	ZZZ
95875		A	Limb exercise test	1.10	1.91	NA	0.07	XXX
95875	TC	A	Limb exercise test	0.00	1.47	NA	0.00	XXX
95875	26	A	Limb exercise test	1.10	0.44	0.44	0.06	XXX
95900		A	Motor nerve conduction test	0.42	1.24	NA	0.02	XXX
95900	TC	A	Motor nerve conduction test	0.00	1.06	NA	0.00	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
95900	26	A	Motor nerve conduction test	0.42	0.18	0.18	0.02	XXX
95903		A	Motor nerve conduction test	0.60	1.33	NA	0.03	XXX
95903	TC	A	Motor nerve conduction test	0.00	1.08	NA	0.00	XXX
95903	26	A	Motor nerve conduction test	0.60	0.24	0.24	0.03	XXX
95904		A	Sense nerve conduction test	0.34	1.12	NA	0.02	XXX
95904	TC	A	Sense nerve conduction test	0.00	0.98	NA	0.00	XXX
95904	26	A	Sense nerve conduction test	0.34	0.14	0.14	0.02	XXX
95920		A	Intraop nerve test add-on	2.11	2.30	2.30	0.12	ZZZ
95920	TC	A	Intraop nerve test add-on	0.00	1.44	1.44	0.01	ZZZ
95920	26	A	Intraop nerve test add-on	2.11	0.86	0.86	0.11	ZZZ
95921		A	Autonomic nerv function test	0.90	1.29	NA	0.04	XXX
95921	TC	A	Autonomic nerv function test	0.00	0.96	NA	0.00	XXX
95921	26	A	Autonomic nerv function test	0.90	0.33	0.33	0.04	XXX
95922		A	Autonomic nerv function test	0.96	1.79	NA	0.05	XXX
95922	TC	A	Autonomic nerv function test	0.00	1.43	NA	0.00	XXX
95922	26	A	Autonomic nerv function test	0.96	0.36	0.36	0.04	XXX
95923		A	Autonomic nerv function test	0.90	3.30	NA	0.05	XXX
95923	TC	A	Autonomic nerv function test	0.00	2.95	NA	0.00	XXX
95923	26	A	Autonomic nerv function test	0.90	0.36	0.36	0.05	XXX
95925		A	Somatosensory testing	0.54	4.19	NA	0.03	XXX
95925	TC	A	Somatosensory testing	0.00	3.97	NA	0.00	XXX
95925	26	A	Somatosensory testing	0.54	0.22	0.22	0.03	XXX
95926		A	Somatosensory testing	0.54	4.04	NA	0.03	XXX
95926	TC	A	Somatosensory testing	0.00	3.83	NA	0.00	XXX
95926	26	A	Somatosensory testing	0.54	0.21	0.21	0.03	XXX
95927		A	Somatosensory testing	0.54	3.44	NA	0.03	XXX
95927	TC	A	Somatosensory testing	0.00	3.22	NA	0.00	XXX
95927	26	A	Somatosensory testing	0.54	0.21	0.21	0.03	XXX
95928		A	C motor evoked, uppr limbs	1.50	5.48	NA	0.09	XXX
95928	TC	A	C motor evoked, uppr limbs	0.00	4.87	NA	0.00	XXX
95928	26	A	C motor evoked, uppr limbs	1.50	0.61	0.61	0.09	XXX
95929		A	C motor evoked, lwr limbs	1.50	5.92	NA	0.09	XXX
95929	TC	A	C motor evoked, lwr limbs	0.00	5.31	NA	0.00	XXX
95929	26	A	C motor evoked, lwr limbs	1.50	0.61	0.61	0.09	XXX
95930		A	Visual evoked potential test	0.35	3.51	NA	0.02	XXX
95930	TC	A	Visual evoked potential test	0.00	3.36	NA	0.00	XXX
95930	26	A	Visual evoked potential test	0.35	0.15	0.15	0.02	XXX
95933		A	Blink reflex test	0.59	1.60	NA	0.03	XXX
95933	TC	A	Blink reflex test	0.00	1.36	NA	0.00	XXX
95933	26	A	Blink reflex test	0.59	0.24	0.24	0.03	XXX
95934		A	H-reflex test	0.51	1.15	NA	0.03	XXX
95934	TC	A	H-reflex test	0.00	0.93	NA	0.00	XXX

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CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
95934	26	A	H-reflex test	0.51	0.21	0.21	0.03	XXX
95936		A	H-reflex test	0.55	0.77	NA	0.03	XXX
95936	TC	A	H-reflex test	0.00	0.55	NA	0.00	XXX
95936	26	A	H-reflex test	0.55	0.22	0.22	0.03	XXX
95937		A	Neuromuscular junction test	0.65	1.17	NA	0.05	XXX
95937	TC	A	Neuromuscular junction test	0.00	0.91	NA	0.00	XXX
95937	26	A	Neuromuscular junction test	0.65	0.26	0.26	0.05	XXX
95950		A	Ambulatory eeg monitoring	1.51	7.10	NA	0.09	XXX
95950	TC	A	Ambulatory eeg monitoring	0.00	6.50	NA	0.00	XXX
95950	26	A	Ambulatory eeg monitoring	1.51	0.60	0.60	0.08	XXX
95951		C	EEG monitoring/videorecord	0.00	NA	NA	0.00	XXX
95951	TC	C	EEG monitoring/videorecord	0.00	NA	NA	0.00	XXX
95951	26	A	EEG monitoring/videorecord	5.99	2.41	2.41	0.37	XXX
95953		A	EEG monitoring/computer	3.30	10.69	NA	0.20	XXX
95953	TC	A	EEG monitoring/computer	0.00	9.36	NA	0.01	XXX
95953	26	A	EEG monitoring/computer	3.30	1.33	1.33	0.19	XXX
95954		A	EEG monitoring/giving drugs	2.45	6.35	NA	0.15	XXX
95954	TC	A	EEG monitoring/giving drugs	0.00	5.67	NA	0.01	XXX
95954	26	A	EEG monitoring/giving drugs	2.45	0.67	0.67	0.14	XXX
95955		A	EEG during surgery	1.01	3.87	3.87	0.06	XXX
95955	TC	A	EEG during surgery	0.00	3.47	3.47	0.00	XXX
95955	26	A	EEG during surgery	1.01	0.40	0.40	0.06	XXX
95956		A	Eeg monitoring, cable/radio	3.08	18.79	NA	0.18	XXX
95956	TC	A	Eeg monitoring, cable/radio	0.00	17.61	NA	0.01	XXX
95956	26	A	Eeg monitoring, cable/radio	3.08	1.18	1.18	0.18	XXX
95957		A	EEG digital analysis	1.98	8.38	NA	0.12	XXX
95957	TC	A	EEG digital analysis	0.00	7.60	NA	0.01	XXX
95957	26	A	EEG digital analysis	1.98	0.79	0.79	0.12	XXX
95958		A	EEG monitoring/function test	4.24	9.18	NA	0.26	XXX
95958	TC	A	EEG monitoring/function test	0.00	7.57	NA	0.01	XXX
95958	26	A	EEG monitoring/function test	4.24	1.61	1.61	0.24	XXX
95961		A	Electrode stimulation, brain	2.97	4.28	NA	0.18	XXX
95961	TC	A	Electrode stimulation, brain	0.00	3.06	NA	0.01	XXX
95961	26	A	Electrode stimulation, brain	2.97	1.23	1.23	0.17	XXX
95962		A	Electrode stim, brain add-on	3.21	3.18	3.18	0.19	ZZZ
95962	TC	A	Electrode stim, brain add-on	0.00	1.88	1.88	0.01	ZZZ
95962	26	A	Electrode stim, brain add-on	3.21	1.30	1.30	0.18	ZZZ
95965		C	Meg, spontaneous	0.00	0.00	NA	0.00	XXX
95965	TC	C	Meg, spontaneous	0.00	0.00	NA	0.00	XXX
95965	26	A	Meg, spontaneous	7.99	3.23	3.23	0.48	XXX
95966		C	Meg, evoked, single	0.00	0.00	NA	0.00	XXX
95966	TC	C	Meg, evoked, single	0.00	0.00	NA	0.00	XXX
95967		C	Meg, evoked, each add'l	0.00	0.00	NA	0.00	ZZZ
95967	TC	C	Meg, evoked, each add'l	0.00	0.00	NA	0.00	ZZZ
95967	26	A	Meg, evoked, each add'l	3.49	1.41	1.41	0.21	ZZZ
95970		A	Analyze neurostim, no prog	0.45	1.23	0.18	0.03	XXX
95971		A	Analyze neurostim, simple	0.78	0.68	0.27	0.05	XXX
95972		A	Analyze neurostim, complex	1.50	1.32	0.57	0.12	XXX
95973		A	Analyze neurostim, complex	0.92	0.72	0.37	0.07	ZZZ
95974		A	Cranial neurostim, complex	3.00	2.08	1.15	0.19	XXX
95975		A	Cranial neurostim, complex	1.70	1.02	0.68	0.10	ZZZ
95978		A	Analyze neurostim brain/1h	3.50	2.65	1.45	0.29	XXX
95979		A	Analyz neurostim brain addon	1.64	1.07	0.68	0.11	ZZZ
95980		A	Io anal gast n-stim init	0.80	NA	0.34	0.13	XXX
95981		A	Io anal gast n-stim subsq	0.30	0.51	0.17	0.03	XXX
95982		A	Io ga n-stim subsq w/reprog	0.65	0.69	0.31	0.06	XXX
95990		A	Spin/brain pump refil & main	0.00	2.17	NA	0.00	XXX
95991		A	Spin/brain pump refil & main	0.77	2.24	0.29	0.05	XXX
95992		I	Canalith repositioning proc	0.75	0.39	0.27	0.04	XXX
95999		C	Neurological procedure	0.00	0.00	0.00	0.00	XXX
96000		A	Motion analysis, video/3d	1.80	NA	0.71	0.09	XXX
96001		A	Motion test w/ft press meas	2.15	NA	0.76	0.10	XXX
96002		A	Dynamic surface emg	0.41	NA	0.15	0.02	XXX
96003		A	Dynamic fine wire emg	0.37	NA	0.15	0.02	XXX
96004		A	Phys review of motion tests	2.14	0.88	0.88	0.11	XXX
96020		C	Functional brain mapping	0.00	NA	NA	0.00	XXX
96020	TC	C	Functional brain mapping	0.00	NA	NA	0.00	XXX
96020	26	A	Functional brain mapping	3.43	1.04	1.04	0.25	XXX
96040		B	Genetic counseling, 30 min	0.00	1.07	NA	0.00	XXX
96101		A	Psycho testing by psych/phys	1.86	0.24	0.23	0.06	XXX
96102		A	Psycho testing by technician	0.50	0.99	0.10	0.03	XXX
96103		A	Psycho testing admin by comp	0.51	1.12	0.16	0.02	XXX
96105		A	Assessment of aphasia	0.00	2.51	NA	0.00	XXX
96110		A	Developmental test, lim	0.00	0.20	NA	0.00	XXX
96111		A	Developmental test, extend	2.60	1.02	0.88	0.12	XXX
96116		A	Neurobehavioral status exam	1.86	0.59	0.46	0.07	XXX
96118		A	Neuropsych tst by psych/phys	1.86	0.58	0.21	0.05	XXX
96119		A	Neuropsych testing by tec	0.55	1.19	0.07	0.02	XXX
96120		A	Neuropsych tst admin w/comp	0.51	1.81	0.14	0.02	XXX
96125		A	Cognitive test by hc pro	1.70	1.04	0.62	0.05	XXX
96150		A	Assess hlth/behave, init	0.50	0.06	0.05	0.01	XXX
96151		A	Assess hlth/behave, subseq	0.48	0.06	0.05	0.01	XXX
96152		A	Intervene hlth/behave, indiv	0.46	0.06	0.05	0.01	XXX

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CPT[1]/HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
96153		A	Intervene hlth/behave, group	0.10	0.02	0.01	0.00	XXX
96154		A	Interv hlth/behav, fam w/pt	0.45	0.05	0.05	0.01	XXX
96155		N	Interv hlth/behav fam no pt	0.44	0.16	0.16	0.02	XXX
96360		A	Hydration iv infusion, init	0.17	1.12	NA	0.01	XXX
96361		A	Hydrate iv infusion, add-on	0.09	0.26	NA	0.00	ZZZ
96365		A	Ther/proph/diag iv inf, init	0.21	1.43	NA	0.01	XXX
96366		A	Ther/proph/diag iv inf addon	0.18	0.34	NA	0.01	ZZZ
96367		A	Tx/proph/dg addl seq iv inf	0.19	0.54	NA	0.01	ZZZ
96368		A	Ther/diag concurrent inf	0.17	0.28	NA	0.01	ZZZ
96369		A	Sc ther infusion, up to 1 hr	0.21	3.35	NA	0.01	XXX
96370		A	Sc ther infusion, addl hr	0.18	0.22	NA	0.01	ZZZ
96371		A	Sc ther infusion, reset pump	0.00	2.22	NA	0.00	ZZZ
96372		A	Ther/proph/diag inj, sc/im	0.17	0.42	NA	0.01	XXX
96373		A	Ther/proph/diag inj, ia	0.17	0.33	NA	0.01	XXX
96374		A	Ther/proph/diag inj, iv push	0.18	1.09	NA	0.01	XXX
96375		A	Tx/pro/dx inj new drug addon	0.10	0.40	NA	0.00	ZZZ
96379		C	Ther/prop/diag inj/inf proc	0.00	0.00	0.00	0.00	XXX
96401		A	Chemo, anti-neopl, sq/im	0.21	1.48	NA	0.01	XXX
96402		A	Chemo hormon antineopl sq/im	0.19	0.57	NA	0.01	XXX
96405		A	Chemo intralesional, up to 7	0.52	1.48	0.28	0.02	000
96406		A	Chemo intralesional over 7	0.80	1.97	0.38	0.03	000
96409		A	Chemo, iv push, sngl drug	0.24	2.18	NA	0.01	XXX
96411		A	Chemo, iv push, addl drug	0.20	1.17	NA	0.01	ZZZ
96413		A	Chemo, iv infusion, 1 hr	0.28	2.85	NA	0.01	XXX
96415		A	Chemo, iv infusion, addl hr	0.19	0.51	NA	0.01	ZZZ
96416		A	Chemo prolong infuse w/pump	0.21	3.19	NA	0.01	XXX
96417		A	Chemo iv infus each addl seq	0.21	1.35	NA	0.01	ZZZ
96420		A	Chemo, ia, push tecnique	0.17	2.22	NA	0.01	XXX
96422		A	Chemo ia infusion up to 1 hr	0.17	3.59	NA	0.01	XXX
96423		A	Chemo ia infuse each addl hr	0.17	1.59	NA	0.01	ZZZ
96425		A	Chemotherapy,infusion method	0.17	3.80	NA	0.01	XXX
96440		A	Chemotherapy, intracavitary	2.37	18.75	1.06	0.42	000
96445		A	Chemotherapy, intracavitary	2.20	4.35	0.93	0.13	000
96450		A	Chemotherapy, into CNS	1.53	2.86	0.61	0.09	000
96521		A	Refill/maint, portable pump	0.21	2.76	NA	0.01	XXX
96522		A	Refill/maint pump/resvr syst	0.21	2.28	NA	0.01	XXX
96523		T	Irrig drug delivery device	0.04	0.51	NA	0.00	XXX
96542		A	Chemotherapy injection	0.75	1.99	0.35	0.04	XXX
96549		C	Chemotherapy, unspecified	0.00	0.00	0.00	0.00	XXX
96567		A	Photodynamic tx, skin	0.00	3.24	NA	0.00	XXX
96570		A	Photodynamic tx, 30 min	1.10	0.38	0.38	0.14	ZZZ
96571		A	Photodynamic tx, addl 15 min	0.55	0.15	0.15	0.03	ZZZ

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96900		A	Ultraviolet light therapy	0.00	0.49	NA	0.00	XXX
96902		B	Trichogram	0.41	0.17	0.15	0.02	XXX
96904		R	Whole body photography	0.00	1.53	NA	0.00	XXX
96910		A	Photochemotherapy with UV-B	0.00	1.70	NA	0.00	XXX
96912		A	Photochemotherapy with UV-A	0.00	2.18	NA	0.00	XXX
96913		A	Photochemotherapy, UV-A or B	0.00	3.06	NA	0.00	XXX
96920		A	Laser tx, skin < 250 sq cm	1.15	3.24	0.69	0.04	000
96921		A	Laser tx, skin 250-500 sq cm	1.17	3.34	0.69	0.04	000
96922		A	Laser tx, skin > 500 sq cm	2.10	4.29	1.27	0.07	000
96999		C	Dermatological procedure	0.00	0.00	0.00	0.00	XXX
97001		A	Pt evaluation	1.20	0.78	NA	0.04	XXX
97002		A	Pt re-evaluation	0.60	0.49	NA	0.02	XXX
97003		A	Ot evaluation	1.20	1.01	NA	0.05	XXX
97004		A	Ot re-evaluation	0.60	0.74	NA	0.02	XXX
97005		I	Athletic train eval	0.00	0.00	0.00	0.00	XXX
97006		I	Athletic train reeval	0.00	0.00	0.00	0.00	XXX
97010		B	Hot or cold packs therapy	0.06	0.08	NA	0.00	XXX
97012		A	Mechanical traction therapy	0.25	0.17	NA	0.01	XXX
97014		I	Electric stimulation therapy	0.18	0.22	NA	0.01	XXX
97016		A	Vasopneumatic device therapy	0.18	0.30	NA	0.01	XXX
97018		A	Paraffin bath therapy	0.06	0.20	NA	0.00	XXX
97022		A	Whirlpool therapy	0.17	0.40	NA	0.01	XXX
97024		A	Diathermy eg, microwave	0.06	0.10	NA	0.00	XXX
97026		A	Infrared therapy	0.06	0.08	NA	0.00	XXX
97028		A	Ultraviolet therapy	0.08	0.10	NA	0.00	XXX
97032		A	Electrical stimulation	0.25	0.24	NA	0.01	XXX
97033		A	Electric current therapy	0.26	0.34	NA	0.01	XXX
97034		A	Contrast bath therapy	0.21	0.25	NA	0.01	XXX
97035		A	Ultrasound therapy	0.21	0.12	NA	0.01	XXX
97036		A	Hydrotherapy	0.28	0.54	NA	0.02	XXX
97039		C	Physical therapy treatment	0.00	0.00	NA	0.00	XXX
97110		A	Therapeutic exercises	0.45	0.38	NA	0.02	XXX
97112		A	Neuromuscular reeducation	0.45	0.41	NA	0.02	XXX
97113		A	Aquatic therapy/exercises	0.44	0.65	NA	0.01	XXX
97116		A	Gait training therapy	0.40	0.33	NA	0.01	XXX
97124		A	Massage therapy	0.35	0.32	NA	0.01	XXX
97139		C	Physical medicine procedure	0.00	0.00	NA	0.00	XXX
97140		A	Manual therapy	0.43	0.35	NA	0.01	XXX
97150		A	Group therapeutic procedures	0.27	0.26	NA	0.01	XXX
97530		A	Therapeutic activities	0.44	0.46	NA	0.01	XXX
97532		A	Cognitive skills development	0.44	0.26	NA	0.01	XXX
97533		A	Sensory integration	0.44	0.32	NA	0.01	XXX

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97535		A	Self care mngment training	0.45	0.45	NA	0.01	XXX
97537		A	Community/work reintegration	0.45	0.34	NA	0.01	XXX
97542		A	Wheelchair mngment training	0.45	0.35	NA	0.01	XXX
97545		R	Work hardening	0.00	0.00	NA	0.00	XXX
97546		R	Work hardening add-on	0.00	0.00	NA	0.00	ZZZ
97597		A	Active wound care/20 cm or <	0.58	1.35	0.14	0.04	XXX
97598		A	Active wound care > 20 cm	0.80	1.56	0.19	0.06	XXX
97602		B	Wound(s) care non-selective	0.00	0.49	NA	0.00	XXX
97605		A	Neg press wound tx, < 50 cm	0.55	0.49	0.13	0.06	XXX
97606		A	Neg press wound tx, > 50 cm	0.60	0.50	0.14	0.08	XXX
97750		A	Physical performance test	0.45	0.40	NA	0.02	XXX
97755		A	Assistive technology assess	0.62	0.32	NA	0.02	XXX
97760		A	Orthotic mgmt and training	0.45	0.51	NA	0.02	XXX
97761		A	Prosthetic training	0.45	0.39	NA	0.02	XXX
97762		A	C/o for orthotic/prosth use	0.25	0.90	NA	0.01	XXX
97799		C	Physical medicine procedure	0.00	0.00	0.00	0.00	XXX
97802		A	Medical nutrition, indiv, in	0.53	0.10	0.05	0.02	XXX
97803		A	Med nutrition, indiv, subseq	0.45	0.09	0.04	0.02	XXX
97804		A	Medical nutrition, group	0.25	0.03	0.02	0.01	XXX
97810		N	Acupunct w/o stimul 15 min	0.60	0.35	0.22	0.03	XXX
97811		N	Acupunct w/o stimul addl 15m	0.50	0.22	0.18	0.03	ZZZ
97813		N	Acupunct w/stimul 15 min	0.65	0.37	0.24	0.03	XXX
97814		N	Acupunct w/stimul addl 15m	0.55	0.27	0.20	0.03	ZZZ
98925		A	Osteopathic manipulation	0.45	0.37	0.17	0.02	000
98926		A	Osteopathic manipulation	0.65	0.47	0.23	0.03	000
98927		A	Osteopathic manipulation	0.87	0.59	0.29	0.04	000
98928		A	Osteopathic manipulation	1.03	0.66	0.34	0.04	000
98929		A	Osteopathic manipulation	1.19	0.77	0.41	0.05	000
98940		A	Chiropractic manipulation	0.45	0.25	0.13	0.01	000
98941		A	Chiropractic manipulation	0.65	0.32	0.19	0.02	000
98942		A	Chiropractic manipulation	0.87	0.38	0.25	0.02	000
98943		N	Chiropractic manipulation	0.40	0.23	0.15	0.02	XXX
98960		B	Self-mgmt educ & train, 1 pt	0.00	0.63	NA	0.00	XXX
98961		B	Self-mgmt educ/train, 2-4 pt	0.00	0.30	NA	0.00	XXX
98962		B	Self-mgmt educ/train, 5-8 pt	0.00	0.22	NA	0.00	XXX
98966		N	Hc pro phone call 5-10 min	0.25	0.12	0.09	0.01	XXX
98967		N	Hc pro phone call 11-20 min	0.50	0.21	0.18	0.03	XXX
98968		N	Hc pro phone call 21-30 min	0.75	0.31	0.27	0.04	XXX
99000		B	Specimen handling	0.00	0.00	0.00	0.00	XXX
99001		B	Specimen handling	0.00	0.00	0.00	0.00	XXX
99002		B	Device handling	0.00	0.00	0.00	0.00	XXX
99024		B	Postop follow-up visit	0.00	0.00	0.00	0.00	XXX
99050		B	Medical services after hrs	0.00	0.00	0.00	0.00	XXX
99051		B	Med serv, eve/wkend/holiday	0.00	0.00	0.00	0.00	XXX
99053		B	Med serv 10pm-8am, 24 hr fac	0.00	0.00	0.00	0.00	XXX
99056		B	Med service out of office	0.00	0.00	0.00	0.00	XXX
99058		B	Office emergency care	0.00	0.00	0.00	0.00	XXX
99060		B	Out of office emerg med serv	0.00	0.00	0.00	0.00	XXX
99070		B	Special supplies	0.00	0.00	0.00	0.00	XXX
99071		B	Patient education materials	0.00	0.00	0.00	0.00	XXX
99078		B	Group health education	0.00	0.00	0.00	0.00	XXX
99080		B	Special reports or forms	0.00	0.00	0.00	0.00	XXX
99082		C	Unusual physician travel	0.00	0.00	0.00	0.00	XXX
99090		B	Computer data analysis	0.00	0.00	0.00	0.00	XXX
99091		B	Collect/review data from pt	1.10	0.40	NA	0.06	XXX
99100		B	Special anesthesia service	0.00	NA	0.00	0.00	ZZZ
99116		B	Anesthesia with hypothermia	0.00	NA	0.00	0.00	ZZZ
99135		B	Special anesthesia procedure	0.00	NA	0.00	0.00	ZZZ
99140		B	Emergency anesthesia	0.00	NA	0.00	0.00	ZZZ
99143		C	Mod cs by same phys, < 5 yrs	0.00	0.00	NA	0.00	XXX
99144		C	Mod cs by same phys, 5 yrs +	0.00	0.00	NA	0.00	XXX
99145		C	Mod cs by same phys add-on	0.00	0.00	0.00	0.00	ZZZ
99148		C	Mod cs diff phys < 5 yrs	0.00	NA	NA	0.00	XXX
99149		C	Mod cs diff phys 5 yrs +	0.00	NA	NA	0.00	XXX
99150		C	Mod cs diff phys add-on	0.00	NA	0.00	0.00	ZZZ
99170		A	Anogenital exam, child	1.75	1.84	0.70	0.10	000
99173		N	Visual acuity screen	0.00	0.06	NA	0.00	XXX
99174		N	Ocular photoscreening	0.00	0.68	NA	0.00	XXX
99175		A	Induction of vomiting	0.00	0.57	NA	0.00	XXX
99183		A	Hyperbaric oxygen therapy	2.34	3.13	0.81	0.19	XXX
99185		A	Regional hypothermia	0.00	1.27	NA	0.00	XXX
99186		A	Total body hypothermia	0.00	1.36	NA	0.00	XXX
99195		A	Phlebotomy	0.00	2.07	NA	0.00	XXX
99199		C	Special service/proc/report	0.00	0.00	0.00	0.00	XXX
99201		A	Office/outpatient visit, new	0.48	0.62	0.21	0.04	XXX
99202		A	Office/outpatient visit, new	0.93	0.98	0.40	0.06	XXX
99203		A	Office/outpatient visit, new	1.42	1.33	0.59	0.11	XXX
99204		A	Office/outpatient visit, new	2.43	1.82	1.00	0.16	XXX
99205		A	Office/outpatient visit, new	3.17	2.11	1.23	0.21	XXX
99211		A	Office/outpatient visit, est	0.18	0.31	0.07	0.01	XXX
99212		A	Office/outpatient visit, est	0.48	0.62	0.20	0.03	XXX
99213		A	Office/outpatient visit, est	0.97	0.89	0.39	0.05	XXX
99214		A	Office/outpatient visit, est	1.50	1.25	0.58	0.08	XXX
99215		A	Office/outpatient visit, est	2.11	1.60	0.82	0.12	XXX

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CPT[1,2] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
99217		A	Observation care discharge	1.28	NA	0.61	0.06	XXX
99218		A	Observation care	1.28	NA	0.47	0.07	XXX
99219		A	Observation care	2.14	NA	0.80	0.11	XXX
99220		A	Observation care	2.99	NA	1.09	0.15	XXX
99221		A	Initial hospital care	1.92	NA	0.71	0.14	XXX
99222		A	Initial hospital care	2.61	NA	1.00	0.16	XXX
99223		A	Initial hospital care	3.85	NA	1.45	0.21	XXX
99231		A	Subsequent hospital care	0.76	NA	0.29	0.04	XXX
99232		A	Subsequent hospital care	1.39	NA	0.52	0.07	XXX
99233		A	Subsequent hospital care	2.00	NA	0.74	0.10	XXX
99234		A	Observ/hosp same date	2.56	NA	0.95	0.15	XXX
99235		A	Observ/hosp same date	3.41	NA	1.27	0.17	XXX
99236		A	Observ/hosp same date	4.26	NA	1.55	0.22	XXX
99238		A	Hospital discharge day	1.28	NA	0.61	0.06	XXX
99239		A	Hospital discharge day	1.90	NA	0.90	0.09	XXX
99241		N	Office consultation	0.64	0.61	0.23	0.05	XXX
99242		N	Office consultation	1.34	1.00	0.49	0.10	XXX
99243		N	Office consultation	1.88	1.36	0.69	0.13	XXX
99244		N	Office consultation	3.02	1.86	1.10	0.16	XXX
99245		N	Office consultation	3.77	2.24	1.38	0.21	XXX
99251		N	Inpatient consultation	1.00	NA	0.36	0.05	XXX
99252		N	Inpatient consultation	1.50	NA	0.55	0.09	XXX
99253		N	Inpatient consultation	2.27	NA	0.83	0.11	XXX
99254		N	Inpatient consultation	3.29	NA	1.20	0.13	XXX
99255		N	Inpatient consultation	4.00	NA	1.46	0.18	XXX
99281		A	Emergency dept visit	0.45	NA	0.12	0.03	XXX
99282		A	Emergency dept visit	0.88	NA	0.24	0.05	XXX
99283		A	Emergency dept visit	1.34	NA	0.34	0.08	XXX
99284		A	Emergency dept visit	2.56	NA	0.57	0.15	XXX
99285		A	Emergency dept visit	3.80	NA	0.76	0.23	XXX
99288		B	Direct advanced life support	0.00	NA	NA	0.00	XXX
99291		A	Critical care, first hour	4.50	2.54	1.38	0.26	XXX
99292		A	Critical care, addÆl 30 min	2.25	0.93	0.69	0.13	ZZZ
99304		A	Nursing facility care, init	1.64	0.78	0.78	0.11	XXX
99305		A	Nursing facility care, init	2.34	1.06	1.06	0.15	XXX
99306		A	Nursing facility care, init	3.06	1.31	1.31	0.17	XXX
99307		A	Nursing fac care, subseq	0.76	0.41	0.41	0.04	XXX
99308		A	Nursing fac care, subseq	1.16	0.64	0.64	0.05	XXX
99309		A	Nursing fac care, subseq	1.55	0.84	0.84	0.07	XXX
99310		A	Nursing fac care, subseq	2.35	1.18	1.18	0.11	XXX
99315		A	Nursing fac discharge day	1.13	0.58	0.58	0.05	XXX
99316		A	Nursing fac discharge day	1.50	0.73	0.73	0.07	XXX
99318		A	Annual nursing fac assessmnt	1.71	0.82	0.82	0.08	XXX
99324		A	Domicil/r-home visit new pat	1.01	0.45	NA	0.05	XXX
99325		A	Domicil/r-home visit new pat	1.52	0.61	NA	0.08	XXX
99326		A	Domicil/r-home visit new pat	2.63	1.11	NA	0.13	XXX
99327		A	Domicil/r-home visit new pat	3.46	1.47	NA	0.16	XXX
99328		A	Domicil/r-home visit new pat	4.09	1.64	NA	0.18	XXX
99334		A	Domicil/r-home visit est pat	1.07	0.52	NA	0.05	XXX
99335		A	Domicil/r-home visit est pat	1.72	0.79	NA	0.08	XXX
99336		A	Domicil/r-home visit est pat	2.46	1.10	NA	0.11	XXX
99337		A	Domicil/r-home visit est pat	3.58	1.55	NA	0.17	XXX
99339		B	Domicil/r-home care supervis	1.25	0.77	NA	0.07	XXX
99340		B	Domicil/r-home care supervis	1.80	1.04	NA	0.10	XXX
99341		A	Home visit, new patient	1.01	0.44	NA	0.05	XXX
99342		A	Home visit, new patient	1.52	0.57	NA	0.08	XXX
99343		A	Home visit, new patient	2.53	0.96	NA	0.13	XXX
99344		A	Home visit, new patient	3.38	1.44	NA	0.16	XXX
99345		A	Home visit, new patient	4.09	1.73	NA	0.19	XXX
99347		A	Home visit, est patient	1.00	0.46	NA	0.05	XXX
99348		A	Home visit, est patient	1.56	0.67	NA	0.08	XXX
99349		A	Home visit, est patient	2.33	1.06	NA	0.11	XXX
99350		A	Home visit, est patient	3.28	1.44	NA	0.15	XXX
99354		A	Prolonged service, office	1.77	0.83	0.67	0.09	ZZZ
99355		A	Prolonged service, office	1.77	0.80	0.64	0.09	ZZZ
99356		A	Prolonged service, inpatient	1.71	NA	0.69	0.09	ZZZ
99357		A	Prolonged service, inpatient	1.71	NA	0.69	0.09	ZZZ
99358		B	Prolonged serv, w/o contact	2.10	0.80	0.80	0.11	ZZZ
99359		B	Prolonged serv, w/o contact	1.00	0.40	0.40	0.05	ZZZ
99360		X	Physician standby services	1.20	NA	0.44	0.06	XXX
99363		B	Anticoag mgmt, init	1.65	1.60	0.60	0.09	XXX
99364		B	Anticoag mgmt, subseq	0.63	0.48	0.23	0.03	XXX
99366		B	Team conf w/pat by hc pro	0.82	0.32	0.30	0.04	XXX
99367		B	Team conf w/o pat by phys	1.10	NA	0.40	0.06	XXX
99368		B	Team conf w/o pat by hc pro	0.72	NA	0.26	0.04	XXX
99374		B	Home health care supervision	1.10	0.72	0.40	0.06	XXX
99375		I	Home health care supervision	1.73	1.01	0.63	0.09	XXX
99377		B	Hospice care supervision	1.10	0.72	0.40	0.06	XXX
99378		I	Hospice care supervision	1.73	1.01	0.63	0.09	XXX
99379		B	Nursing fac care supervision	1.10	0.72	0.40	0.06	XXX
99380		B	Nursing fac care supervision	1.73	1.01	0.63	0.09	XXX
99381		N	Init pm e/m, new pat, inf	1.19	1.22	0.43	0.06	XXX
99382		N	Init pm e/m, new pat 1-4 yrs	1.36	1.28	0.50	0.07	XXX
99383		N	Prev visit, new, age 5-11	1.36	1.27	0.50	0.07	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
99384		N	Prev visit, new, age 12-17	1.53	1.33	0.56	0.08	XXX
99385		N	Prev visit, new, age 18-39	1.53	1.33	0.56	0.08	XXX
99386		N	Prev visit, new, age 40-64	1.88	1.46	0.69	0.10	XXX
99387		N	Init pm e/m, new pat 65+ yrs	2.06	1.62	0.75	0.11	XXX
99391		N	Per pm reeval, est pat, inf	1.02	1.05	0.37	0.05	XXX
99392		N	Prev visit, est, age 1-4	1.19	1.11	0.43	0.06	XXX
99393		N	Prev visit, est, age 5-11	1.19	1.10	0.43	0.06	XXX
99394		N	Prev visit, est, age 12-17	1.36	1.17	0.50	0.07	XXX
99395		N	Prev visit, est, age 18-39	1.36	1.17	0.50	0.07	XXX
99396		N	Prev visit, est, age 40-64	1.53	1.23	0.56	0.08	XXX
99397		N	Per pm reeval est pat 65+ yr	1.71	1.40	0.62	0.09	XXX
99401		N	Preventive counseling, indiv	0.48	0.45	0.18	0.03	XXX
99402		N	Preventive counseling, indiv	0.98	0.63	0.36	0.05	XXX
99403		N	Preventive counseling, indiv	1.46	0.80	0.53	0.08	XXX
99404		N	Preventive counseling, indiv	1.95	0.98	0.71	0.10	XXX
99406		A	Behav chng smoking 3-10 min	0.24	0.13	0.09	0.01	XXX
99407		A	Behav chng smoking > 10 min	0.50	0.23	0.18	0.03	XXX
99408		N	Audit/dast, 15-30 min	0.65	0.28	0.24	0.03	XXX
99409		N	Audit/dast, over 30 min	1.30	0.52	0.47	0.07	XXX
99411		N	Preventive counseling, group	0.15	0.26	0.05	0.01	XXX
99412		N	Preventive counseling, group	0.25	0.29	0.09	0.01	XXX
99420		N	Health risk assessment test	0.00	0.24	NA	0.00	XXX
99441		N	Phone e/m by phys 5-10 min	0.25	0.12	0.09	0.01	XXX
99442		N	Phone e/m by phys 11-20 min	0.50	0.21	0.18	0.03	XXX
99443		N	Phone e/m by phys 21-30 min	0.75	0.31	0.27	0.04	XXX
99450		N	Basic life disability exam	0.00	0.35	NA	0.00	XXX
99455		R	Work related disability exam	0.00	0.68	NA	0.00	XXX
99456		R	Disability examination	0.00	0.80	NA	0.00	XXX
99460		A	Init nb em per day, hosp	1.17	NA	0.44	0.05	XXX
99461		A	Init nb em per day, non-fac	1.26	1.24	0.46	0.07	XXX
99462		A	Sbsq nb em per day, hosp	0.62	NA	0.23	0.03	XXX
99463		A	Same day nb discharge	1.50	NA	0.70	0.06	XXX
99464		A	Attendance at delivery	1.50	NA	0.51	0.06	XXX
99465		A	Nb resuscitation	2.93	NA	1.07	0.16	XXX
99466		A	Ped crit care transport	4.79	NA	1.78	0.30	XXX
99467		A	Ped crit care transport addl	2.40	NA	0.94	0.11	ZZZ
99468		A	Neonate crit care, initial	18.46	NA	7.00	1.15	XXX
99469		A	Neonate crit care, subsq	7.99	NA	2.69	0.33	XXX
99471		A	Ped critical care, initial	15.98	NA	5.32	0.67	XXX
99472		A	Ped critical care, subsq	7.99	NA	2.76	0.37	XXX
99475		A	Ped crit care age 2-5, init	11.25	3.45	3.45	0.66	XXX
99476		A	Ped crit care age 2-5, subsq	6.75	2.07	2.07	0.39	XXX
99477		A	Init day hosp neonate care	7.00	NA	2.44	0.29	XXX
99478		A	Ic, lbw inf < 1500 gm subsq	2.75	NA	1.08	0.13	XXX
99479		A	Ic lbw inf 1500-2500 g subsq	2.50	NA	0.99	0.12	XXX
99480		A	Ic inf pbw 2501-5000 g subsq	2.40	NA	0.92	0.12	XXX
99499		C	Unlisted e&m service	0.00	0.00	0.00	0.00	XXX
99500		I	Home visit, prenatal	0.00	0.00	0.00	0.00	XXX
99501		I	Home visit, postnatal	0.00	0.00	0.00	0.00	XXX
99502		I	Home visit, nb care	0.00	0.00	0.00	0.00	XXX
99503		I	Home visit, resp therapy	0.00	0.00	0.00	0.00	XXX
99504		I	Home visit mech ventilator	0.00	0.00	0.00	0.00	XXX
99505		I	Home visit, stoma care	0.00	0.00	0.00	0.00	XXX
99506		I	Home visit, im injection	0.00	0.00	0.00	0.00	XXX
99507		I	Home visit, cath maintain	0.00	0.00	0.00	0.00	XXX
99509		I	Home visit day life activity	0.00	0.00	0.00	0.00	XXX
99510		I	Home visit, sting/m/fam couns	0.00	0.00	0.00	0.00	XXX
99511		I	Home visit, fecal/enema mgmt	0.00	0.00	0.00	0.00	XXX
99512		I	Home visit for hemodialysis	0.00	0.00	0.00	0.00	XXX
99600		I	Home visit nos	0.00	0.00	0.00	0.00	XXX
99601		I	Home infusion/visit, 2 hrs	0.00	0.00	0.00	0.00	XXX
99602		I	Home infusion, each addtl hr	0.00	0.00	0.00	0.00	XXX
A4262		B	Temporary tear duct plug	0.00	0.00	0.00	0.00	XXX
A4263		B	Permanent tear duct plug	0.00	0.00	0.00	0.00	XXX
A4270		B	Disposable endoscope sheath	0.00	0.00	0.00	0.00	XXX
A4300		B	Cath impl vasc access portal	0.00	0.00	0.00	0.00	XXX
A4550		B	Surgical trays	0.00	0.00	0.00	0.00	XXX
A4890		R	Repair/maint cont hemo equip	0.00	0.00	0.00	0.00	XXX
G0008		X	Admin influenza virus vac	0.00	0.00	0.00	0.00	XXX
G0009		X	Admin pneumococcal vaccine	0.00	0.00	0.00	0.00	XXX
G0010		X	Admin hepatitis b vaccine	0.00	0.00	0.00	0.00	XXX
G0101		A	CA screen;pelvic/breast exam	0.45	0.52	NA	0.02	XXX
G0102		A	Prostate ca screening; dre	0.17	0.31	0.07	0.01	XXX
G0104		A	CA screen;flexi sigmoidscope	0.96	2.48	0.66	0.07	000
G0105		A	Colorectal scrn; hi risk ind	3.69	6.00	1.84	0.26	000
G0105	53	A	Colorectal scrn: hi risk ind	0.96	2.48	0.66	0.05	000
G0106		A	Colon CA screen;barium enema	0.99	4.43	NA	0.05	XXX
G0106	TC	A	Colon CA screen;barium enema	0.00	4.13	NA	0.00	XXX
G0106	26	A	Colon CA screen;barium enema	0.99	0.30	0.30	0.05	XXX
G0108		A	Diab manage trn per indiv	0.00	0.58	NA	0.00	XXX
G0109		A	Diab manage trn ind/group	0.00	0.30	NA	0.00	XXX
G0117		T	Glaucoma scrn high risk direc	0.45	0.90	NA	0.01	XXX
G0118		T	Glaucoma scrn high risk direc	0.17	0.90	NA	0.00	XXX
G0120		A	Colon ca scrn; barium enema	0.99	4.43	NA	0.05	XXX

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G0120	TC	A	Colon ca scrn; barium enema	0.00	4.13	NA	0.00	XXX
G0120	26	A	Colon ca scrn; barium enema	0.99	0.30	0.30	0.05	XXX
G0121		A	Colon ca scrn not hi rsk ind	3.69	6.00	1.84	0.26	000
G0121	53	A	Colon ca scrn not hi rsk ind	0.96	2.48	0.66	0.05	000
G0122		N	Colon ca scrn; barium enema	0.99	6.20	NA	0.05	XXX
G0122	TC	N	Colon ca scrn; barium enema	0.00	5.84	NA	0.00	XXX
G0122	26	N	Colon ca scrn; barium enema	0.99	0.36	0.36	0.05	XXX
G0124		A	Screen c/v thin layer by MD	0.42	0.35	0.35	0.02	XXX
G0127		R	Trim nail(s)	0.17	0.41	0.04	0.01	000
G0128		R	CORF skilled nursing service	0.08	0.17	NA	0.00	XXX
G0130		A	Single energy x-ray study	0.22	0.62	NA	0.01	XXX
G0130	TC	A	Single energy x-ray study	0.00	0.54	NA	0.00	XXX
G0130	26	A	Single energy x-ray study	0.22	0.09	0.09	0.01	XXX
G0141		A	Scr c/v cyto,autosys and md	0.42	0.35	0.35	0.02	XXX
G0166		A	Extrnl counterpulse, per tx	0.07	3.38	NA	0.00	XXX
G0168		A	Wound closure by adhesive	0.45	1.92	0.27	0.03	000
G0179		A	MD recertification HHA PT	0.45	0.58	NA	0.02	XXX
G0180		A	MD certification HHA patient	0.67	0.68	NA	0.04	XXX
G0181		A	Home health care supervision	1.73	1.06	NA	0.08	XXX
G0182		A	Hospice care supervision	1.73	1.07	NA	0.08	XXX
G0186		C	Dstry eye lesn,fdr vssl tech	0.00	0.00	0.00	0.00	YYY
G0202		A	Screningmammography,digital	0.70	2.80	NA	0.05	XXX
G0202	TC	A	Screningmammography,digital	0.00	2.57	NA	0.00	XXX
G0202	26	A	Screningmammography,digital	0.70	0.24	0.24	0.05	XXX
G0204		A	Diagnosticmammography,digital	0.87	3.40	NA	0.06	XXX
G0204	TC	A	Diagnosticmammography,digital	0.00	3.10	NA	0.00	XXX
G0204	26	A	Diagnosticmammography,digital	0.87	0.30	0.30	0.06	XXX
G0206		A	Diagnosticmammography,digital	0.70	2.67	NA	0.05	XXX
G0206	TC	A	Diagnosticmammography,digital	0.00	2.43	NA	0.00	XXX
G0206	26	A	Diagnosticmammography,digital	0.70	0.24	0.24	0.05	XXX
G0237		A	Therapeutic procd strg endur	0.00	0.21	NA	0.00	XXX
G0238		A	Oth resp proc, indiv	0.00	0.22	NA	0.00	XXX
G0239		A	Oth resp proc, group	0.00	0.27	NA	0.00	XXX
G0245		R	Initial foot exam pt lops	0.88	0.98	0.40	0.05	XXX
G0246		R	Followup eval of foot pt lop	0.45	0.62	0.20	0.02	XXX
G0247		R	Routine footcare pt w lops	0.50	0.73	0.16	0.03	ZZZ
G0248		R	Demonstrate use home inr mon	0.00	2.83	NA	0.00	XXX
G0249		R	Provide INR test mater/equip	0.00	2.74	NA	0.00	XXX
G0250		R	MD INR test revie inter mgmt	0.18	0.06	NA	0.01	XXX
G0252	26	N	PET imaging initial dx	1.50	0.55	0.55	0.08	XXX
G0268		A	Removal of impacted wax md	0.61	0.76	0.29	0.02	000
G0269		B	Occlusive device in vein art	0.00	0.00	0.00	0.00	XXX

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[4] Global totals for malpractice RVUs may not sum due to rounding.

CPT[1,7] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
G0270		A	MNT subs tx for change dx	0.45	0.09	0.04	0.02	XXX
G0271		A	Group MNT 2 or more 30 mins	0.25	0.03	0.02	0.01	XXX
G0275		A	Renal angio, cardiac cath	0.25	NA	0.08	0.01	ZZZ
G0278		A	Iliac art angio,cardiac cath	0.25	NA	0.08	0.01	ZZZ
G0281		A	Elec stim unattend for press	0.18	0.17	NA	0.01	XXX
G0282		N	Elect stim wound care not pd	0.00	0.12	NA	0.00	XXX
G0283		A	Elec stim other than wound	0.18	0.17	NA	0.01	XXX
G0288		A	Recon, CTA for surg plan	0.00	0.85	NA	0.00	XXX
G0289		A	Arthro, loose body + chondro	1.48	NA	0.73	0.22	ZZZ
G0329		A	Electromagnetic tx for ulcers	0.06	0.19	NA	0.00	XXX
G0337		X	Hospice evaluation preelecti	1.42	0.00	0.00	0.11	XXX
G0339		C	Robot lin-radsurg com, first	0.00	0.00	0.00	0.00	XXX
G0340		C	Robt lin-radsurg fractx 2-5	0.00	0.00	0.00	0.00	XXX
G0341		A	Percutaneous islet celltrans	6.98	3.03	NA	0.37	000
G0342		A	Laparoscopy islet cell trans	11.92	NA	6.76	0.64	090
G0343		A	Laparotomy islet cell transp	19.85	NA	11.43	1.06	090
G0364		A	Bone marrow aspirate &biopsy	0.16	0.15	0.07	0.01	ZZZ
G0365		A	Vessel mapping hemo access	0.25	5.25	NA	0.03	XXX
G0365	TC	A	Vessel mapping hemo access	0.00	5.17	NA	0.00	XXX
G0365	26	A	Vessel mapping hemo access	0.25	0.08	0.08	0.03	XXX
G0372		A	MD service required for PMD	0.17	0.07	0.07	0.01	XXX
G0389		A	Ultrasound exam AAA screen	0.58	2.10	NA	0.04	XXX
G0389	TC	A	Ultrasound exam AAA screen	0.00	1.92	NA	0.00	XXX
G0389	26	A	Ultrasound exam AAA screen	0.58	0.18	0.18	0.04	XXX
G0392		A	AV fistula or graft arterial	9.48	39.25	3.20	0.66	000
G0393		A	AV fistula or graft venous	6.03	31.10	2.14	0.44	000
G0396		A	Alcohol/subs interv 15-30mn	0.65	0.26	0.21	0.03	XXX
G0397		A	Alcohol/subs interv >30 min	1.30	0.52	0.47	0.07	XXX
G0398		C	Home sleep test/type 2 Porta	0.00	0.00	NA	0.00	XXX
G0398	TC	C	Home sleep test/type 2 Porta	0.00	0.00	NA	0.00	XXX
G0398	26	C	Home sleep test/type 2 Porta	0.00	0.00	0.00	0.00	XXX
G0399		C	Home sleep test/type 3 Porta	0.00	0.00	NA	0.00	XXX
G0399	TC	C	Home sleep test/type 3 Porta	0.00	0.00	NA	0.00	XXX
G0399	26	C	Home sleep test/type 3 Porta	0.00	0.00	0.00	0.00	XXX
G0400		C	Home sleep test/type 4 Porta	0.00	0.00	NA	0.00	XXX
G0400	TC	C	Home sleep test/type 4 Porta	0.00	0.00	NA	0.00	XXX
G0400	26	C	Home sleep test/type 4 Porta	0.00	0.00	0.00	0.00	XXX
G0402		A	Initial preventive exam	2.30	1.84	NA	0.06	XXX
G0403		A	EKG for initial prevent exam	0.17	0.33	0.33	0.01	XXX
G0404		A	EKG tracing for initial prev	0.00	0.00	NA	0.00	XXX
G0405		A	EKG interpret & report preve	0.17	0.07	0.07	0.01	XXX
G0406		A	Telhealth inpt consult 15min	0.76	NA	0.29	0.04	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
G0407		A	Telheath inpt consult 25min	1.39	NA	0.52	0.07	XXX
G0408		A	Telhealth inpt consult 35min	2.00	NA	0.74	0.11	XXX
G0409		A	CORF related serv 15 mins ea	0.00	0.23	NA	0.00	XXX
G0412		A	Open tx iliac spine uni/bil	10.45	NA	7.73	1.56	090
G0413		A	Pelvic ring fracture uni/bil	15.73	NA	10.83	2.31	090
G0414		A	Pelvic ring fx treat int fix	14.65	NA	10.50	2.16	090
G0415		A	Open tx post pelvic fxcture	20.93	NA	13.73	3.21	090
G0416		A	Sat biopsy prostate 1-20 spc	3.09	1.13	NA	0.17	XXX
G0416	TC	A	Sat biopsy prostate 1-20 spc	0.00	0.00	NA	0.01	XXX
G0416	26	A	Sat biopsy prostate 1-20 spc	3.09	1.13	1.13	0.16	XXX
G0417		A	Sat biopsy prostate 21-40	5.86	2.14	NA	0.31	XXX
G0417	TC	A	Sat biopsy prostate 21-40	0.00	0.00	NA	0.02	XXX
G0417	26	A	Sat biopsy prostate 21-40	5.86	2.14	2.14	0.30	XXX
G0418		A	Sat biopsy prostate 41-60	10.30	3.76	NA	0.55	XXX
G0418	TC	A	Sat biopsy prostate 41-60	0.00	0.00	NA	0.03	XXX
G0418	26	A	Sat biopsy prostate 41-60	10.30	3.76	3.76	0.52	XXX
G0419		A	Sat biopsy prostate: >60	11.61	4.24	NA	0.62	XXX
G0419	TC	A	Sat biopsy prostate: >60	0.00	0.00	NA	0.03	XXX
G0419	26	A	Sat biopsy prostate: >60	11.61	4.24	4.24	0.59	XXX
G9041		A	Low vision rehab occupationa	0.54	0.22	0.22	0.02	XXX
G9042		A	Low vision rehab orient/mobi	0.20	0.20	0.20	0.01	XXX
G9043		A	Low vision lowvision therapi	0.20	0.20	0.20	0.00	XXX
G9044		A	Low vision rehabilate teache	0.19	0.15	0.15	0.00	XXX
G9050		I	Oncology work-up evaluation	0.00	0.00	0.00	0.00	XXX
G9051		I	Oncology tx decision-mgmt	0.00	0.00	0.00	0.00	XXX
G9052		I	Onc surveillance for disease	0.00	0.00	0.00	0.00	XXX
G9053		I	Onc expectant management pt	0.00	0.00	0.00	0.00	XXX
G9054		I	Onc supervision palliative	0.00	0.00	0.00	0.00	XXX
G9055		I	Onc visit unspecified NOS	0.00	0.00	0.00	0.00	XXX
G9056		I	Onc prac mgmt adheres guide	0.00	0.00	0.00	0.00	XXX
G9057		I	Onc pract mgmt differs trial	0.00	0.00	0.00	0.00	XXX
G9058		I	Onc prac mgmt disagree w/gui	0.00	0.00	0.00	0.00	XXX
G9059		I	Onc prac mgmt pt opt alterna	0.00	0.00	0.00	0.00	XXX
G9060		I	Onc prac mgmt dif pt comorb	0.00	0.00	0.00	0.00	XXX
G9061		I	Onc prac cond noadd by guide	0.00	0.00	0.00	0.00	XXX
G9062		I	Onc prac guide differs nos	0.00	0.00	0.00	0.00	XXX
GXX26		A	Ed svc CKD ind per session	0.53	0.10	0.05	0.02	XXX
GXX27		A	Ed svc CKD grp per session	0.25	0.03	0.02	0.01	XXX
GXX28		A	Intens cardiac rehab w/exerc	See 2010 OPPS Rule	See 2010 OPPS Rule	See 2010 OPPS Rule	See 2010 OPPS Rule	XXX
GXX29		A	Intens cardiac rehab no exer	See 2010	See 2010	See 2010	See 2010	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
GXX30		A	Pulmonary rehab w exer	OPPS Rule 0.18	OPPS Rule 0.40	OPPS Rule 0.40	OPPS Rule 0.01	XXX
M0064		A	Visit for drug monitoring	0.37	0.91	0.06	0.01	XXX
P3001		A	Screening pap smear by phys	0.42	0.35	0.35	0.02	XXX
P7001		I	Culture bacterial urine	0.00	0.00	0.00	0.00	XXX
Q0035		A	Cardiokymography	0.17	0.26	NA	0.01	XXX
Q0035	TC	A	Cardiokymography	0.00	0.21	NA	0.00	XXX
Q0035	26	A	Cardiokymography	0.17	0.05	0.05	0.01	XXX
Q0091		A	Obtaining screen pap smear	0.37	0.75	0.14	0.02	XXX
Q0092		A	Set up port xray equipment	0.00	0.38	0.38	0.00	XXX
Q3001		C	Brachytherapy Radioelements	0.00	0.00	0.00	0.00	XXX
Q3026		I	Subc inj interferon beta-1a	0.00	0.00	0.00	0.00	XXX
Q3031		B	Collagen skin test	0.00	0.00	0.00	0.00	XXX
R0070		C	Transport portable x-ray	0.00	0.00	NA	0.00	XXX
R0075		C	Transport port x-ray multipl	0.00	0.00	NA	0.00	XXX
R0076		B	Transport portable EKG	0.00	0.00	NA	0.00	XXX
V5299		R	Hearing service	0.00	0.00	0.00	0.00	XXX

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ADDENDUM C: [Reserved]

ADDENDUM D: Proposed 2010 Geographic Adjustment Factors (GAFs)

Contractor	Locality	Locality Name	2010** GAF
00831	01	Alaska	1.288***
01102	06	San Mateo, CA	1.204
01102	05	San Francisco, CA	1.201
13202	01	Manhattan, NY	1.164
13202	02	NYC Suburbs/Long I., NY	1.162
01102	09	Santa Clara, CA	1.148
12402	01	Northern NJ	1.134
31143	01	Metropolitan Boston	1.134
01102	07	Oakland/Berkley, CA	1.131
13292	04	Queens, NY	1.130
01192	26	Anaheim/Santa Ana, CA	1.128
12202	01	DC + MD/VA Suburbs	1.121
01192	17	Ventura, CA	1.121
00590	04	Miami, FL	1.114
01192	18	Los Angeles, CA	1.112
01102	03	Marin/Napa/Solano, CA	1.112
13102	00	Connecticut	1.100
00952	16	Chicago, IL	1.085
12402	99	Rest of New Jersey	1.082
12502	01	Metropolitan Philadelphia, PA	1.075
00953	01	Detroit, MI	1.072
00952	15	Suburban Chicago, IL	1.063
01202	01	Hawaii/Guam	1.056
00590	03	Fort Lauderdale, FL	1.050
00524	01	Rhode Island	1.045
31143	99	Rest of Massachusetts	1.041
12302	01	Baltimore/Surr. Cntys, MD	1.035
13202	03	Poughkpsie/N NYC Suburbs, NY	1.034
00836	02	Seattle (King Cnty), WA	1.033
01302	00	Nevada	1.016
04402	18	Houston, TX	1.016
12102	01	Delaware	1.014
01102	99	Rest of California*	1.012
01192	99	Rest of California*	1.012
00528	01	New Orleans, LA	1.010
04402	11	Dallas, TX	1.010
00511	01	Atlanta, GA	1.005
00952	12	East St. Louis, IL	0.989
00973	50	Virgin Islands	0.989
00835	01	Portland, OR	0.987
04402	31	Austin, TX	0.987

Contractor	Locality	Locality Name	2010** GAF
00590	99	Rest of Florida	0.987
31144	40	New Hampshire	0.986
04402	15	Galveston, TX	0.986
04402	09	Brazoria, TX	0.985
12302	99	Rest of Maryland	0.984
04402	28	Fort Worth, TX	0.982
31142	03	Southern Maine	0.980
05302	02	Metropolitan Kansas City, MO	0.978
04102	01	Colorado	0.975
00883	00	Ohio	0.973
00836	99	Rest of Washington	0.970
05392	01	Metropolitan St Louis, MO	0.969
00953	99	Rest of Michigan	0.968
03102	00	Arizona	0.968
12502	99	Rest of Pennsylvania	0.966
00954	00	Minnesota	0.959
31145	50	Vermont	0.956
00904	00	Virginia	0.952
04402	20	Beaumont, TX	0.950
03502	09	Utah	0.948
00952	99	Rest of Illinois	0.943
13282	99	Rest of New York	0.941
04202	05	New Mexico	0.941
00630	00	Indiana	0.941
05535	00	North Carolina	0.938
00951	00	Wisconsin	0.936
04402	99	Rest of Texas	0.933
00511	99	Rest of Georgia	0.931
00835	99	Rest of Oregon	0.930
00528	99	Rest of Louisiana	0.927
05440	35	Tennessee	0.924
00880	01	South Carolina	0.924
00884	16	West Virginia	0.924
05202	00	Kansas	0.915
05130	00	Idaho	0.914
31142	99	Rest of Maine	0.913
00660	00	Kentucky	0.909
00512	00	Mississippi	0.907
00510	00	Alabama	0.907
03602	21	Wyoming	0.904
05102	00	Iowa	0.903
04302	00	Oklahoma	0.901
05402	00	Nebraska	0.901
05392	99	Rest of Missouri*	0.895
05302	99	Rest of Missouri*	0.895
03202	01	Montana	0.894
00520	13	Arkansas	0.891
03402	02	South Dakota	0.888
03302	01	North Dakota	0.880
00973	20	Puerto Rico	0.787

GAF equation: (0.52466 * work GPCI) + (0.43669 * pe GPCI) + (0.03865 * mp GPCI).

*Indicates multiple contractors.

**GAF values do not reflect the 1.000 floor on physician work GPCI established by the MIPPA.

***GAF value for Alaska reflects 1.500 floor on physician work GPCI established by the MIPPA.

ADDENDUM E: Proposed CY 2010 Geographic Practice Cost Indices (GPCIs) by State and Medicare Locality

Contractor	Locality	Locality Name	Work** GPCI	PE GPCI	MP GPCI
00510	00	Alabama	0.982	0.853	0.496
00831	01	Alaska	1.500***	1.090	0.646
03102	00	Arizona	0.988	0.957	0.822
00520	13	Arkansas	0.961	0.846	0.446
01192	26	Anaheim/Santa Ana, CA	1.034	1.269	0.811
01192	18	Los Angeles, CA	1.041	1.225	0.804
01102	03	Marin/Napa/Solano, CA	1.034	1.265	0.432
01102	07	Oakland/Berkley, CA	1.053	1.286	0.425
01102	05	San Francisco, CA	1.059	1.441	0.414
01102	06	San Mateo, CA	1.072	1.433	0.394
01102	09	Santa Clara, CA	1.083	1.294	0.377
01192	17	Ventura, CA	1.027	1.265	0.766
01102	99	Rest of California*	1.007	1.058	0.549
01192	99	Rest of California*	1.007	1.058	0.549
04102	01	Colorado	0.986	0.992	0.641
13102	00	Connecticut	1.038	1.185	0.980
12202	01	DC + MD/VA Suburbs	1.047	1.218	1.032
12102	01	Delaware	1.011	1.046	0.678
00590	03	Fort Lauderdale, FL	0.989	1.018	2.250
00590	04	Miami, FL	1.000	1.069	3.167
00590	99	Rest of Florida	0.973	0.939	1.724
00511	01	Atlanta, GA	1.009	1.014	0.836
00511	99	Rest of Georgia	0.979	0.883	0.829
01202	01	Hawaii/Guam	0.998	1.161	0.665
05130	00	Idaho	0.967	0.883	0.546
00952	16	Chicago, IL	1.025	1.080	1.940
00952	12	East St. Louis, IL	0.989	0.919	1.793
00952	15	Suburban Chicago, IL	1.017	1.068	1.629
00952	99	Rest of Illinois	0.975	0.880	1.219
00630	00	Indiana	0.986	0.918	0.599
05102	00	Iowa	0.965	0.870	0.434
05202	00	Kansas	0.969	0.882	0.557
00660	00	Kentucky	0.969	0.860	0.652
00528	01	New Orleans, LA	0.986	1.044	0.956
00528	99	Rest of Louisiana	0.970	0.878	0.892
31142	03	Southern Maine	0.980	1.025	0.492
31142	99	Rest of Maine	0.962	0.893	0.492
12302	01	Baltimore/Surr. Cntys, MD	1.012	1.057	1.086
12302	99	Rest of Maryland	0.994	0.982	0.874
31143	01	Metropolitan Boston	1.029	1.291	0.764
31143	99	Rest of Massachusetts	1.007	1.106	0.764
00953	01	Detroit, MI	1.036	1.040	1.906
00953	99	Rest of Michigan	0.998	0.923	1.083
00954	00	Minnesota	0.992	0.983	0.245
00512	00	Mississippi	0.959	0.854	0.808
05302	02	Metropolitan Kansas City, MO	0.990	0.945	1.188
05392	01	Metropolitan St Louis, MO	0.993	0.931	1.075
05392	99	Rest of Missouri*	0.949	0.821	0.997
05302	99	Rest of Missouri*	0.949	0.821	0.997
03202	01	Montana	0.950	0.847	0.673
05402	00	Nebraska	0.959	0.890	0.245
01302	00	Nevada	1.002	1.026	1.083
31144	40	New Hampshire	0.982	1.039	0.462
12402	01	Northern NJ	1.057	1.228	1.116
12402	99	Rest of New Jersey	1.042	1.126	1.116
04202	05	New Mexico	0.973	0.890	1.096
13202	01	Manhattan, NY	1.064	1.298	1.010
13202	02	NYC Suburbs/Long I., NY	1.051	1.289	1.235
13202	03	Poughkpsie/N NYC Suburbs, NY	1.014	1.077	0.822
13292	04	Queens, NY	1.032	1.239	1.220
13282	99	Rest of New York	0.997	0.921	0.425
05535	00	North Carolina	0.972	0.925	0.634
03302	01	North Dakota	0.947	0.844	0.387
00883	00	Ohio	0.993	0.927	1.232
04302	00	Oklahoma	0.964	0.850	0.627
00835	01	Portland, OR	1.002	1.015	0.472
00835	99	Rest of Oregon	0.968	0.927	0.472
12502	01	Metropolitan Philadelphia, PA	1.016	1.097	1.617
12502	99	Rest of Pennsylvania	0.993	0.925	1.081
00973	20	Puerto Rico	0.904	0.694	0.250
00524	01	Rhode Island	1.013	1.088	0.996
00880	01	South Carolina	0.975	0.906	0.446
03402	02	South Dakota	0.942	0.864	0.420
05440	35	Tennessee	0.978	0.889	0.608
04402	31	Austin, TX	0.992	0.984	0.969
04402	20	Beaumont, TX	0.984	0.875	1.346
04402	09	Brazoria, TX	1.019	0.922	1.223
04402	11	Dallas, TX	1.009	1.001	1.110
04402	28	Fort Worth, TX	0.998	0.953	1.110
04402	15	Galveston, TX	0.991	0.959	1.223
04402	18	Houston, TX	1.016	0.986	1.345
04402	99	Rest of Texas	0.968	0.879	1.065
03502	09	Utah	0.977	0.907	1.026
31145	50	Vermont	0.968	0.983	0.489
00904	00	Virginia	0.982	0.942	0.657
00973	50	Virgin Islands	0.997	0.978	1.009

Contractor	Locality	Locality Name	Work** GPCI	PE GPCI	MP GPCI
00836	02	Seattle (King Cnty), WA	1.014	1.085	0.706
00836	99	Rest of Washington	0.987	0.974	0.693
00884	16	West Virginia	0.973	0.827	1.353
00951	00	Wisconsin	0.988	0.921	0.409
03602	21	Wyoming	0.956	0.842	0.889

* Indicates multiple contractors.
** CY 2010 work GPCI does not reflect the 1.000 floor established by the MIPPA which expires 01/01/2010.
*** CY 2010 work GPCI reflects 1.500 floor in Alaska established by the MIPPA.

ADDENDUM F: CY 2010 ESRD Wage Index for Urban Areas Based on CBSA Labor Market Areas

CBSA Code	Urban Area (Constituent Counties)	Wage Index
10180	Abilene, TX Callahan County, TX Jones County, TX Taylor County, TX	0.8413
10380	Aguadilla-Isabela-San Sebastián, PR Aguada Municipio, PR Aguadilla Municipio, PR Añasco Municipio, PR Isabela Municipio, PR Lares Municipio, PR Moca Municipio, PR Rincón Municipio, PR San Sebastián Municipio, PR	0.6876
10420	Akron, OH Portage County, OH Summit County, OH	0.9371
10500	Albany, GA Baker County, GA Dougherty County, GA Lee County, GA Terrell County, GA Worth County, GA	0.9423
10580	Albany-Schenectady-Troy, NY Albany County, NY Rensselaer County, NY Saratoga County, NY Schenectady County, NY Schoharie County, NY	0.9299
10740	Albuquerque, NM Bernalillo County, NM Sandoval County, NM Torrance County, NM Valencia County, NM	0.9953
10780	Alexandria, LA Grant Parish, LA Rapides Parish, LA	0.8484

CBSA Code	Urban Area (Constituent Counties)	Wage Index
10900	Allentown-Bethlehem-Easton, PA-NJ	1.0199
	Warren County, NJ	
	Carbon County, PA	
	Lehigh County, PA	
	Northampton County, PA	
11020	Altoona, PA	0.9385
	Blair County, PA	
11100	Amarillo, TX	0.9200
	Armstrong County, TX	
	Carson County, TX	
	Potter County, TX	
	Randall County, TX	
11180	Ames, IA	1.0055
	Story County, IA	
11260	Anchorage, AK	1.2720
	Anchorage Municipality, AK	
	Matanuska-Susitna Borough, AK	
11300	Anderson, IN	0.9584
	Madison County, IN	
11340	Anderson, SC	0.9330
	Anderson County, SC	
11460	Ann Arbor, MI	1.0898
	Washtenaw County, MI	
11500	Anniston-Oxford, AL	0.8093
	Calhoun County, AL	
11540	Appleton, WI	0.9836
	Calumet County, WI	
	Outagamie County, WI	
11700	Asheville, NC	0.9605
	Buncombe County, NC	
	Haywood County, NC	
	Henderson County, NC	
	Madison County, NC	
12020	Athens-Clarke County, GA	1.0051
	Clarke County, GA	
	Madison County, GA	
	Oconee County, GA	
	Oglethorpe County, GA	
12060	Atlanta-Sandy Springs-Marietta, GA	1.0307
	Barrow County, GA	
	Bartow County, GA	
	Butts County, GA	
	Carroll County, GA	
	Cherokee County, GA	
	Clayton County, GA	
	Cobb County, GA	
	Coweta County, GA	
	Dawson County, GA	
	DeKalb County, GA	
	Douglas County, GA	
	Fayette County, GA	
	Forsyth County, GA	
	Fulton County, GA	
	Gwinnett County, GA	
	Haralson County, GA	
	Heard County, GA	
	Henry County, GA	
	Jasper County, GA	
	Lamar County, GA	
	Meriwether County, GA	
	Newton County, GA	
	Paulding County, GA	
	Pickens County, GA	
	Pike County, GA	
	Rockdale County, GA	
	Spalding County, GA	
	Walton County, GA	
12100	Atlantic City-Hammonton, NJ	1.2234
	Atlantic County, NJ	
12220	Auburn-Opelika, AL	0.8618
	Lee County, AL	
12260	Augusta-Richmond County, GA-SC	0.9653
	Burke County, GA	
	Columbia County, GA	
	McDuffie County, GA	
	Richmond County, GA	
	Aiken County, SC	
	Edgefield County, SC	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
12420	Austin-Round Rock, TX Bastrop County, TX Caldwell County, TX Hays County, TX Travis County, TX Williamson County, TX	1.0087
12540	Bakersfield, CA Kern County, CA	1.1864
12580	Baltimore-Towson, MD Anne Arundel County, MD Baltimore County, MD Carroll County, MD Harford County, MD Howard County, MD Queen Anne's County, MD Baltimore City, MD	1.0815
12620	Bangor, ME Penobscot County, ME	1.0751
12700	Barnstable Town, MA Barnstable County, MA	1.3360
12940	Baton Rouge, LA Ascension Parish, LA East Baton Rouge Parish, LA East Feliciana Parish, LA Iberville Parish, LA Livingston Parish, LA Pointe Coupee Parish, LA St. Helena Parish, LA West Baton Rouge Parish, LA West Feliciana Parish, LA	0.8661
12980	Battle Creek, MI Calhoun County, MI	1.0588
13020	Bay City, MI Bay County, MI	0.9813
13140	Beaumont-Port Arthur, TX Hardin County, TX Jefferson County, TX Orange County, TX	0.8877
13380	Bellingham, WA Whatcom County, WA	1.0266
13460	Bend, OR Deschutes County, OR	1.2120
13644	Bethesda-Frederick-Gaithersburg, MD Frederick County, MD Montgomery County, MD	1.0904
13740	Billings, MT Carbon County, MT Yellowstone County, MT	0.9299
13780	Binghamton, NY Broome County, NY Tioga County, NY	0.9294
13820	Birmingham-Hoover, AL Bibb County, AL Blount County, AL Chilton County, AL Jefferson County, AL St. Clair County, AL Shelby County, AL Walker County, AL	0.9024
13900	Bismarck, ND Burleigh County, ND Morton County, ND	0.8086
13980	Blacksburg-Christiansburg-Radford, VA Giles County, VA Montgomery County, VA Pulaski County, VA Radford City, VA	0.8866
14020	Bloomington, IN Greene County, IN Monroe County, IN Owen County, IN	0.9554
14060	Bloomington-Normal, IL McLean County, IL	0.9930
14260	Boise City-Nampa, ID Ada County, ID Boise County, ID Canyon County, ID Gem County, ID Owyhee County, ID	0.9835
14484	Boston-Quincy, MA Norfolk County, MA Plymouth County, MA Suffolk County, MA	1.2864

CBSA Code	Urban Area (Constituent Counties)	Wage Index
14500	Boulder, CO Boulder County, CO	1.0871
14540	Bowling Green, KY Edmonson County, KY Warren County, KY	0.8965
14600	Bradenton-Sarasota-Venice, FL Manatee County, FL Sarasota County, FL	1.0305
14740	Bremerton-Silverdale, WA Kitsap County, WA	1.1388
14860	Bridgeport-Stamford-Norwalk, CT Fairfield County, CT	1.3539
15180	Brownsville-Harlingen, TX Cameron County, TX	0.9552
15260	Brunswick, GA Brantley County, GA Glynn County, GA McIntosh County, GA	0.9913
15380	Buffalo-Niagara Falls, NY Erie County, NY Niagara County, NY	1.0303
15500	Burlington, NC Alamance County, NC	0.9264
15540	Burlington-South Burlington, VT Chittenden County, VT Franklin County, VT Grand Isle County, VT	1.0702
15764	Cambridge-Newton-Framingham, MA Middlesex County, MA	1.1941
15804	Camden, NJ Burlington County, NJ Camden County, NJ Gloucester County, NJ	1.0733
15940	Canton-Massillon, OH Carroll County, OH Stark County, OH	0.9313
15980	Cape Coral-Fort Myers, FL Lee County, FL	0.9610
16180	Carson City, NV Carson City, NV	1.1150
16020	Cape Girardeau-Jackson, MO-IL Alexander County, IL Bollinger County, MO Cape Girardeau County, MO	0.9579
16220	Casper, WY Natrona County, WY	1.0081
16300	Cedar Rapids, IA Benton County, IA Jones County, IA Linn County, IA	0.9513
16580	Champaign-Urbana, IL Champaign County, IL Ford County, IL Piatt County, IL	1.0703
16620	Charleston, WV Boone County, WV Clay County, WV Kanawha County, WV Lincoln County, WV Putnam County, WV	0.8621
16700	Charleston-North Charleston-Summerville, SC Berkeley County, SC Charleston County, SC Dorchester County, SC	0.9794
16740	Charlotte-Gastonia-Concord, NC-SC Anson County, NC Cabarrus County, NC Gaston County, NC Mecklenburg County, NC Union County, NC York County, SC	1.0032
16820	Charlottesville, VA Albemarle County, VA Fluvanna County, VA Greene County, VA Nelson County, VA Charlottesville City, VA	0.9923

CBSA Code	Urban Area (Constituent Counties)	Wage Index
16860	Chattanooga, TN-GA Catoosa County, GA Dade County, GA Walker County, GA Hamilton County, TN Marion County, TN Sequatchie County, TN	0.9351
16940	Cheyenne, WY Laramie County, WY	0.9894
16974	Chicago-Naperville-Joliet, IL Cook County, IL DeKalb County, IL DuPage County, IL Grundy County, IL Kane County, IL Kendall County, IL McHenry County, IL Will County, IL	1.1085
17020	Chico, CA Butte County, CA	1.1858
17140	Cincinnati-Middletown, OH-KY-IN Dearborn County, IN Franklin County, IN Ohio County, IN Boone County, KY Bracken County, KY Campbell County, KY Gallatin County, KY Grant County, KY Kenton County, KY Pendleton County, KY Brown County, OH Butler County, OH Clermont County, OH Hamilton County, OH Warren County, OH	1.0037
17300	Clarksville, TN-KY Christian County, KY Trigg County, KY Montgomery County, TN Stewart County, TN	0.8449
17420	Cleveland, TN Bradley County, TN Polk County, TN	0.8009
17460	Cleveland-Elyria-Mentor, OH Cuyahoga County, OH Geauga County, OH Lake County, OH Lorain County, OH Medina County, OH	0.9438
17660	Coeur d'Alene, ID Kootenai County, ID	0.9778
17780	College Station-Bryan, TX Brazos County, TX Burleson County, TX Robertson County, TX	1.0057
17820	Colorado Springs, CO El Paso County, CO Teller County, CO	1.0399
17860	Columbia, MO Boone County, MO Howard County, MO	0.9124
17900	Columbia, SC Calhoun County, SC Fairfield County, SC Kershaw County, SC Lexington County, SC Richland County, SC Saluda County, SC	0.9264
17980	Columbus, GA-AL Russell County, AL Chattahoochee County, GA Harris County, GA Marion County, GA Muscogee County, GA	0.9237
18020	Columbus, IN Bartholomew County, IN	1.0096

CBSA Code	Urban Area (Constituent Counties)	Wage Index
18140	Columbus, OH	1.0676
	Delaware County, OH	
	Fairfield County, OH	
	Franklin County, OH	
	Licking County, OH	
	Madison County, OH	
	Morrow County, OH	
	Pickaway County, OH	
	Union County, OH	
18580	Corpus Christi, TX	0.9205
	Aransas County, TX	
	Nueces County, TX	
	San Patricio County, TX	
18700	Corvallis, OR	1.1651
	Benton County, OR	
19060	Cumberland, MD-WV	0.8519
	Allegany County, MD	
	Mineral County, WV	
19124	Dallas-Plano-Irving, TX	1.0482
	Collin County, TX	
	Dallas County, TX	
	Delta County, TX	
	Denton County, TX	
	Ellis County, TX	
	Hunt County, TX	
	Kaufman County, TX	
	Rockwall County, TX	
19140	Dalton, GA	0.9176
	Murray County, GA	
	Whitfield County, GA	
19180	Danville, IL	0.9252
	Vermilion County, IL	
19260	Danville, VA	0.8813
	Pittsylvania County, VA	
	Danville City, VA	
19340	Davenport-Moline-Rock Island, IA-IL	0.8771
	Henry County, IL	
	Mercer County, IL	
	Rock Island County, IL	
	Scott County, IA	
19380	Dayton, OH	0.9754
	Greene County, OH	
	Miami County, OH	
	Montgomery County, OH	
	Preble County, OH	
19460	Decatur, AL	0.8258
	Lawrence County, AL	
	Morgan County, AL	
19500	Decatur, IL	0.8465
	Macon County, IL	
19660	Deltona-Daytona Beach-Ormond Beach, FL	0.9388
	Volusia County, FL	
19740	Denver-Aurora-Broomfield, CO	1.1354
	Adams County, CO	
	Arapahoe County, CO	
	Broomfield County, CO	
	Clear Creek County, CO	
	Denver County, CO	
	Douglas County, CO	
	Elbert County, CO	
	Gilpin County, CO	
	Jefferson County, CO	
	Park County, CO	
19780	Des Moines-West Des Moines, IA	1.0217
	Dallas County, IA	
	Guthrie County, IA	
	Madison County, IA	
	Polk County, IA	
	Warren County, IA	
19804	Detroit-Livonia-Dearborn, MI	1.0301
	Wayne County, MI	
20020	Dothan, AL	0.7842
	Geneva County, AL	
	Henry County, AL	
	Houston County, AL	
20100	Dover, DE	1.0515
	Kent County, DE	
20220	Dubuque, IA	0.9391
	Dubuque County, IA	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
20260	Duluth, MN-WI Carlton County, MN St. Louis County, MN Douglas County, WI	1.1063
20500	Durham-Chapel Hill, NC Chatham County, NC Durham County, NC Orange County, NC Person County, NC	1.0101
20740	Eau Claire, WI Chippewa County, WI Eau Claire County, WI	1.0129
20764	Edison-New Brunswick, NJ Middlesex County, NJ Monmouth County, NJ Ocean County, NJ Somerset County, NJ	1.1713
20940	El Centro, CA Imperial County, CA	0.9282
21060	Elizabethtown, KY Hardin County, KY Larue County, KY	0.8882
21140	Elkhart-Goshen, IN Elkhart County, IN	1.0047
21300	Elmira, NY Chemung County, NY	0.8831
21340	El Paso, TX El Paso County, TX	0.9044
21500	Erie, PA Erie County, PA	0.8954
21660	Eugene-Springfield, OR Lane County, OR	1.1684
21780	Evansville, IN-KY Gibson County, IN Posey County, IN Vanderburgh County, IN Warrick County, IN Henderson County, KY Webster County, KY	0.9024
21820	Fairbanks, AK Fairbanks North Star Borough, AK	1.1768
21940	Fajardo, PR Ceiba Municipio, PR Fajardo Municipio, PR Luquillo Municipio, PR	0.6876
22020	Fargo, ND-MN Cass County, ND Clay County, MN	0.8654
22140	Farmington, NM San Juan County, NM	0.8353
22180	Fayetteville, NC Cumberland County, NC Hoke County, NC	0.9908
22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR Madison County, AR Washington County, AR McDonald County, MO	0.9280
22380	Flagstaff, AZ Coconino County, AZ	1.3209
22420	Flint, MI Genesee County, MI	1.1779
22500	Florence, SC Darlington County, SC Florence County, SC	0.8612
22520	Florence-Muscle Shoals, AL Colbert County, AL Lauderdale County, AL	0.8443
22540	Fond du Lac, WI Fond du Lac County, WI	1.0229
22660	Fort Collins-Loveland, CO Larimer County, CO	1.0774
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL Broward County, FL	1.0995
22900	Fort Smith, AR-OK Crawford County, AR Franklin County, AR Sebastian County, AR Le Flore County, OK Sequoyah County, OK	0.8323
23020	Fort Walton Beach-Crestview-Destin, FL Okaloosa County, FL	0.9273

CBSA Code	Urban Area (Constituent Counties)	Wage Index
23060	Fort Wayne, IN Allen County, IN Wells County, IN Whitley County, IN	0.9542
23104	Fort Worth-Arlington, TX Johnson County, TX Parker County, TX Tarrant County, TX Wise County, TX	1.0058
23420	Fresno, CA Fresno County, CA	1.1903
23460	Gadsden, AL Etowah County, AL	0.8753
23540	Gainesville, FL Alachua County, FL Gilchrist County, FL	0.9507
23580	Gainesville, GA Hall County, GA	0.9660
23844	Gary, IN Jasper County, IN Lake County, IN Newton County, IN Porter County, IN	0.9848
24020	Glens Falls, NY Warren County, NY Washington County, NY	0.8954
24140	Goldsboro, NC Wayne County, NC	0.9589
24220	Grand Forks, ND-MN Polk County, MN Grand Forks County, ND	0.8232
24300	Grand Junction, CO Mesa County, CO	1.0293
24340	Grand Rapids-Wyoming, MI Barry County, MI Ionia County, MI Kent County, MI Newaygo County, MI	0.9719
24500	Great Falls, MT Cascade County, MT	0.8845
24540	Greeley, CO Weld County, CO	1.0142
24580	Green Bay, WI Brown County, WI Kewaunee County, WI Oconto County, WI	1.0187
24660	Greensboro-High Point, NC Guilford County, NC Randolph County, NC Rockingham County, NC	0.9596
24780	Greenville, NC Greene County, NC Pitt County, NC	0.9955
24860	Greenville-Mauldin-Easley, SC Greenville County, SC Laurens County, SC Pickens County, SC	1.0515
25020	Guayama, PR Arroyo Municipio, PR Guayama Municipio, PR Patillas Municipio, PR	0.6876
25060	Gulfport-Biloxi, MS Hancock County, MS Harrison County, MS Stone County, MS	0.9300
25180	Hagerstown-Martinsburg, MD-WV Washington County, MD Berkeley County, WV Morgan County, WV	0.9492
25260	Hanford-Corcoran, CA Kings County, CA	1.1658
25420	Harrisburg-Carlisle, PA Cumberland County, PA Dauphin County, PA Perry County, PA	0.9832
25500	Harrisonburg, VA Rockingham County, VA Harrisonburg City, VA	0.9556
25540	Hartford-West Hartford-East Hartford, CT Hartford County, CT Middlesex County, CT Tolland County, CT	1.1838

CBSA Code	Urban Area (Constituent Counties)	Wage Index
25620	Hattiesburg, MS Forrest County, MS Lamar County, MS Perry County, MS	0.8113
25860	Hickory-Lenoir-Morganton, NC Alexander County, NC Burke County, NC Caldwell County, NC Catawba County, NC	0.9526
25980	Hinesville-Fort Stewart, GA Liberty County, GA Long County, GA	0.9552
26100	Holland-Grand Haven, MI Ottawa County, MI	0.9208
26180	Honolulu, HI Honolulu County, HI	1.2339
26300	Hot Springs, AR Garland County, AR	0.9535
26380	Houma-Bayou Cane-Thibodaux, LA Lafourche Parish, LA Terrebonne Parish, LA	0.8338
26420	Houston-Sugar Land-Baytown, TX Austin County, TX Brazoria County, TX Chambers County, TX Fort Bend County, TX Galveston County, TX Harris County, TX Liberty County, TX Montgomery County, TX San Jacinto County, TX Waller County, TX	1.0412
26580	Huntington-Ashland, WV-KY-OH Boyd County, KY Greenup County, KY Lawrence County, OH Cabell County, WV Wayne County, WV	0.9632
26620	Huntsville, AL Limestone County, AL Madison County, AL	0.9598
26820	Idaho Falls, ID Bonneville County, ID Jefferson County, ID	0.9992
26900	Indianapolis-Carmel, IN Boone County, IN Brown County, IN Hamilton County, IN Hancock County, IN Hendricks County, IN Johnson County, IN Marion County, IN Morgan County, IN Putnam County, IN Shelby County, IN	1.0505
26980	Iowa City, IA Johnson County, IA Washington County, IA	1.0110
27060	Ithaca, NY Tompkins County, NY	1.0707
27100	Jackson, MI Jackson County, MI	0.9233
27140	Jackson, MS Copiah County, MS Hinds County, MS Madison County, MS Rankin County, MS Simpson County, MS	0.8667
27180	Jackson, TN Chester County, TN Madison County, TN	0.9086
27260	Jacksonville, FL Baker County, FL Clay County, FL Duval County, FL Nassau County, FL St. Johns County, FL	0.9642
27340	Jacksonville, NC Onslow County, NC	0.8498
27500	Janesville, WI Rock County, WI	0.9742

CBSA Code	Urban Area (Constituent Counties)	Wage Index
27620	Jefferson City, MO	0.9222
	Callaway County, MO	
	Cole County, MO	
	Moniteau County, MO	
	Osage County, MO	
27740	Johnson City, TN	0.7914
	Carter County, TN	
	Unicoi County, TN	
	Washington County, TN	
27780	Johnstown, PA	0.8718
	Cambria County, PA	
27860	Jonesboro, AR	0.8176
	Craighead County, AR	
	Poinsett County, AR	
27900	Joplin, MO	0.8772
	Jasper County, MO	
	Newton County, MO	
28020	Kalamazoo-Portage, MI	1.0868
	Kalamazoo County, MI	
	Van Buren County, MI	
28100	Kankakee-Bradley, IL	1.0772
	Kankakee County, IL	
28140	Kansas City, MO-KS	1.0263
	Franklin County, KS	
	Johnson County, KS	
	Leavenworth County, KS	
	Linn County, KS	
	Miami County, KS	
	Wyandotte County, KS	
	Bates County, MO	
	Caldwell County, MO	
	Cass County, MO	
	Clay County, MO	
	Clinton County, MO	
	Jackson County, MO	
	Lafayette County, MO	
	Platte County, MO	
	Ray County, MO	
28420	Kennewick-Pasco-Richland, WA	1.1063
	Benton County, WA	
	Franklin County, WA	
28660	Killeen-Temple-Fort Hood, TX	0.9214
	Bell County, TX	
	Coryell County, TX	
	Lampasas County, TX	
28700	Kingsport-Bristol-Bristol, TN-VA	0.8436
	Hawkins County, TN	
	Sullivan County, TN	
	Bristol City, VA	
	Scott County, VA	
	Washington County, VA	
28740	Kingston, NY	0.9918
	Ulster County, NY	
28940	Knoxville, TN	0.8345
	Anderson County, TN	
	Blount County, TN	
	Knox County, TN	
	Loudon County, TN	
	Union County, TN	
29020	Kokomo, IN	1.0394
	Howard County, IN	
	Tipton County, IN	
29100	La Crosse, WI-MN	1.0498
	Houston County, MN	
	La Crosse County, WI	
29140	Lafayette, IN	0.9721
	Benton County, IN	
	Carroll County, IN	
	Tippecanoe County, IN	
29180	Lafayette, LA	0.9017
	Lafayette Parish, LA	
	St. Martin Parish, LA	
29340	Lake Charles, LA	0.8456
	Calcasieu Parish, LA	
	Cameron Parish, LA	
29404	Lake County-Kenosha County, IL-WI	1.1092
	Lake County, IL	
	Kenosha County, WI	
29420	Lake Havasu City-Kingman, AZ	1.1189
	Mohave County, AZ	
29460	Lakeland-Winter Haven, FL	0.8884
	Polk County, FL	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
29540	Lancaster, PA Lancaster County, PA	0.9745
29620	Lansing-East Lansing, MI Clinton County, MI Eaton County, MI Ingham County, MI	1.0218
29700	Laredo, TX Webb County, TX	0.8550
29740	Las Cruces, NM Dona Ana County, NM	0.9465
29820	Las Vegas-Paradise, NV Clark County, NV	1.2835
29940	Lawrence, KS Douglas County, KS	0.9085
30020	Lawton, OK Comanche County, OK	0.8309
30140	Lebanon, PA Lebanon County, PA	0.8597
30300	Lewiston, ID-WA Nez Perce County, ID Asotin County, WA	1.0134
30340	Lewiston-Auburn, ME Androscoggin County, ME	0.9619
30460	Lexington-Fayette, KY Bourbon County, KY Clark County, KY Fayette County, KY Jessamine County, KY Scott County, KY Woodford County, KY	0.9412
30620	Lima, OH Allen County, OH	0.9913
30700	Lincoln, NE Lancaster County, NE Seward County, NE	1.0126
30780	Little Rock-North Little Rock-Conway, AR Faulkner County, AR Grant County, AR Lonoke County, AR Perry County, AR Pulaski County, AR Saline County, AR	0.9045
30860	Logan, UT-ID Franklin County, ID Cache County, UT	0.9522
30980	Longview, TX Gregg County, TX Rusk County, TX Upshur County, TX	0.8522
31020	Longview, WA Cowlitz County, WA	1.1336
31084	Los Angeles-Long Beach-Santa Ana, CA Los Angeles County, CA	1.2721
31140	Louisville-Jefferson County, KY-IN Clark County, IN Floyd County, IN Harrison County, IN Washington County, IN Bullitt County, KY Henry County, KY Meade County, KY Nelson County, KY Oldham County, KY Shelby County, KY Spencer County, KY Trimble County, KY	0.9491
31180	Lubbock, TX Crosby County, TX Lubbock County, TX	0.9266
31340	Lynchburg, VA Amherst County, VA Appomattox County, VA Bedford County, VA Campbell County, VA Bedford City, VA Lynchburg City, VA	0.9023
31420	Macon, GA Bibb County, GA Crawford County, GA Jones County, GA Monroe County, GA Twiggs County, GA	1.0404
31460	Madera-Chowchilla, CA Madera County, CA	0.8426

CBSA Code	Urban Area (Constituent Counties)	Wage Index
31540	Madison, WI Columbia County, WI Dane County, WI Iowa County, WI	1.1896
31700	Manchester-Nashua, NH Hillsborough County, NH	1.0769
31740	Manhattan, KS Geary County, KS Pottawatomie County, KS Riley County, KS	0.9579
31860	Mankato-North Mankato, MN Blue Earth County, MN Nicollet County, MN	0.9717
31900	Mansfield, OH Richland County, OH	0.9635
32420	Mayagüez, PR Hormigueros Municipio, PR Mayagüez Municipio, PR	0.6876
32580	McAllen-Edinburg-Mission, TX Hidalgo County, TX	0.9339
32780	Medford, OR Jackson County, OR	1.0677
32820	Memphis, TN-MS-AR Crittenden County, AR DeSoto County, MS Marshall County, MS Tate County, MS Tunica County, MS Fayette County, TN Shelby County, TN Tipton County, TN	0.9814
32900	Merced, CA Merced County, CA	1.1057
33124	Miami-Miami Beach-Kendall, FL Miami-Dade County, FL	1.0541
33140	Michigan City-La Porte, IN LaPorte County, IN	0.9860
33260	Midland, TX Midland County, TX	1.0108
33340	Milwaukee-Waukesha-West Allis, WI Milwaukee County, WI Ozaukee County, WI Washington County, WI Waukesha County, WI	1.0748
33460	Minneapolis-St. Paul-Bloomington, MN-WI Anoka County, MN Carver County, MN Chisago County, MN Dakota County, MN Hennepin County, MN Isanti County, MN Ramsey County, MN Scott County, MN Sherburne County, MN Washington County, MN Wright County, MN Pierce County, WI St. Croix County, WI	1.1751
33540	Missoula, MT Missoula County, MT	0.9748
33660	Mobile, AL Mobile County, AL	0.8243
33700	Modesto, CA Stanislaus County, CA	1.3238
33740	Monroe, LA Ouachita Parish, LA Union Parish, LA	0.8208
33780	Monroe, MI Monroe County, MI	0.9408
33860	Montgomery, AL Autauga County, AL Elmore County, AL Lowndes County, AL Montgomery County, AL	0.8793
34060	Morgantown, WV Monongalia County, WV Preston County, WV	0.8957
34100	Morristown, TN Grainger County, TN Hamblen County, TN Jefferson County, TN	0.7625

CBSA Code	Urban Area (Constituent Counties)	Wage Index
34580	Mount Vernon-Anacortes, WA Skagit County, WA	1.1068
34620	Muncie, IN Delaware County, IN	0.8724
34740	Muskegon-Norton Shores, MI Muskegon County, MI	1.0401
34820	Myrtle Beach-North Myrtle Beach-Conway, SC Horry County, SC	0.9242
34900	Napa, CA Napa County, CA	1.5285
34940	Naples-Marco Island, FL Collier County, FL	1.0231
34980	Nashville-Davidson–Murfreesboro--Franklin, TN Cannon County, TN Cheatham County, TN Davidson County, TN Dickson County, TN Hickman County, TN Macon County, TN Robertson County, TN Rutherford County, TN Smith County, TN Sumner County, TN Trousdale County, TN Williamson County, TN Wilson County, TN	1.0262
35004	Nassau-Suffolk, NY Nassau County, NY Suffolk County, NY	1.3193
35084	Newark-Union, NJ-PA Essex County, NJ Hunterdon County, NJ Morris County, NJ Sussex County, NJ Union County, NJ Pike County, PA	1.2081
35300	New Haven-Milford, CT New Haven County, CT	1.2161
35380	New Orleans-Metairie-Kenner, LA Jefferson Parish, LA Orleans Parish, LA Plaquemines Parish, LA St. Bernard Parish, LA St. Charles Parish, LA St. John the Baptist Parish, LA St. Tammany Parish, LA	0.9627
35644	New York-White Plains-Wayne, NY-NJ Bergen County, NJ Hudson County, NJ Passaic County, NJ Bronx County, NY Kings County, NY New York County, NY Putnam County, NY Queens County, NY Richmond County, NY Rockland County, NY Westchester County, NY	1.3734
35660	Niles-Benton Harbor, MI Berrien County, MI	0.9427
35980	Norwich-New London, CT New London County, CT	1.2069
36084	Oakland-Fremont-Hayward, CA Alameda County, CA Contra Costa County, CA	1.7276
36100	Ocala, FL Marion County, FL	0.9060
36140	Ocean City, NJ Cape May County, NJ	1.0758
36220	Odessa, TX Ector County, TX	1.0442
36260	Ogden-Clearfield, UT Davis County, UT Morgan County, UT Weber County, UT	0.9911

CBSA Code	Urban Area (Constituent Counties)	Wage Index
36420	Oklahoma City, OK Canadian County, OK County, OK Grady County, OK Lincoln County, OK Logan County, OK McClain County, OK Oklahoma County, OK	0.9425
36500	Olympia, WA Thurston County, WA	1.2209
36540	Omaha-Council Bluffs, NE-IA Harrison County, IA Mills County, IA Pottawattamie County, IA Cass County, NE Douglas County, NE Sarpy County, NE Saunders County, NE Washington County, NE	1.0174
36740	Orlando-Kissimmee, FL Lake County, FL Orange County, FL Osceola County, FL Seminole County, FL	0.9483
36780	Oshkosh-Neenah, WI Winnebago County, WI	0.9690
36980	Owensboro, KY Daviess County, KY Hancock County, KY McLean County, KY	0.8849
37100	Oxnard-Thousand Oaks-Ventura, CA Ventura County, CA	1.3011
37340	Palm Bay-Melbourne-Titusville, FL Brevard County, FL	0.9594
37380	Palm Coast, FL Flagler County, FL	1.0168
37460	Panama City-Lynn Haven-Panama City, FL Bay County, FL	0.8814
37620	Parkersburg-Marietta-Vienna, WV-OH Washington County, OH Pleasants County, WV Wirt County, WV Wood County, WV	0.8170
37700	Pascagoula, MS George County, MS Jackson County, MS	0.8930
37764	Peabody, MA Essex County, MA	1.1511
37860	Pensacola-Ferry Pass-Brent, FL Escambia County, FL Santa Rosa County, FL	0.8792
37900	Peoria, IL Marshall County, IL Peoria County, IL Stark County, IL Tazewell County, IL Woodford County, IL	0.9650
37964	Philadelphia, PA Bucks County, PA Chester County, PA Delaware County, PA Montgomery County, PA Philadelphia County, PA	1.1356
38060	Phoenix-Mesa-Scottsdale, AZ Maricopa County, AZ Pinal County, AZ	1.1256
38220	Pine Bluff, AR Cleveland County, AR Jefferson County, AR Lincoln County, AR	0.7710
38300	Pittsburgh, PA Allegheny County, PA Armstrong County, PA Beaver County, PA Butler County, PA Fayette County, PA Washington County, PA Westmoreland County, PA	0.9102
38340	Pittsfield, MA Berkshire County, MA	1.1286

CBSA Code	Urban Area (Constituent Counties)	Wage Index
38540	Pocatello, ID Bannock County, ID Power County, ID	0.9782
38660	Ponce, PR Juana Díaz Municipio, PR Ponce Municipio, PR Villalba Municipio, PR	0.6876
38860	Portland-South Portland-Biddeford, ME Cumberland County, ME Sagadahoc County, ME York County, ME	1.0786
38900	Portland-Vancouver-Beaverton, OR-WA Clackamas County, OR Columbia County, OR Multnomah County, OR Washington County, OR Yamhill County, OR Clark County, WA Skamania County, WA	1.2168
38940	Port St. Lucie, FL Martin County, FL St. Lucie County, FL	1.0479
39100	Poughkeepsie-Newburgh-Middletown, NY Dutchess County, NY Orange County, NY	1.1889
39140	Prescott, AZ Yavapai County, AZ	1.0716
39300	Providence-New Bedford-Fall River, RI-MA Bristol County, MA Bristol County, RI Kent County, RI Newport County, RI Providence County, RI Washington County, RI	1.1417
39340	Provo-Orem, UT Juab County, UT Utah County, UT	1.0109
39380	Pueblo, CO Pueblo County, CO	0.9075
39460	Punta Gorda, FL Charlotte County, FL	0.9290
39540	Racine, WI Racine County, WI	0.9924
39580	Raleigh-Cary, NC Franklin County, NC Johnston County, NC Wake County, NC	1.0215
39660	Rapid City, SD Meade County, SD Pennington County, SD	1.0637
39740	Reading, PA Berks County, PA	0.9808
39820	Redding, CA Shasta County, CA	1.4839
39900	Reno-Sparks, NV Storey County, NV Washoe County, NV	1.0891
40060	Richmond, VA Amelia County, VA Caroline County, VA Charles City County, VA Chesterfield County, VA Cumberland County, VA Dinwiddie County, VA Goochland County, VA Hanover County, VA Henrico County, VA King and Queen County, VA King William County, VA Louisa County, VA New Kent County, VA Powhatan County, VA Prince George County, VA Sussex County, VA Colonial Heights City, VA Hopewell City, VA Petersburg City, VA Richmond City, VA	1.0082
40140	Riverside-San Bernardino-Ontario, CA Riverside County, CA San Bernardino County, CA	1.1884

CBSA Code	Urban Area (Constituent Counties)	Wage Index
40220	Roanoke, VA Botetourt County, VA Craig County, VA Franklin County, VA Roanoke County, VA Roanoke City, VA Salem City, VA	0.9142
40340	Rochester, MN Dodge County, MN Olmsted County, MN Wabasha County, MN	1.1791
40380	Rochester, NY Livingston County, NY Monroe County, NY Ontario County, NY Orleans County, NY Wayne County, NY	0.9153
40420	Rockford, IL Boone County, IL Winnebago County, IL	1.0750
40484	Rockingham County, NH Rockingham County, NH Strafford County, NH	1.0721
40580	Rocky Mount, NC Edgecombe County, NC Nash County, NC	0.9365
40660	Rome, GA Floyd County, GA	0.9440
40900	Sacramento--Arden-Arcade--Roseville, CA El Dorado County, CA Placer County, CA Sacramento County, CA Yolo County, CA	1.4843
40980	Saginaw-Saginaw Township North, MI Saginaw County, MI	0.9655
41060	St. Cloud, MN Benton County, MN Stearns County, MN	1.1761
41100	St. George, UT Washington County, UT	0.9780
41140	St. Joseph, MO-KS Doniphan County, KS Andrew County, MO Buchanan County, MO DeKalb County, MO	1.0788
41180	St. Louis, MO-IL Bond County, IL Calhoun County, IL Clinton County, IL Jersey County, IL Macoupin County, IL Madison County, IL Monroe County, IL St. Clair County, IL Crawford County, MO Franklin County, MO Jefferson County, MO Lincoln County, MO St. Charles County, MO St. Louis County, MO Warren County, MO Washington County, MO St. Louis City, MO	0.9637
41420	Salem, OR Marion County, OR Polk County, OR	1.1621
41500	Salinas, CA Monterey County, CA	1.6102
41540	Salisbury, MD Somerset County, MD Wicomico County, MD	0.9647
41620	Salt Lake City, UT Salt Lake County, UT Summit County, UT Tooele County, UT	0.9930
41660	San Angelo, TX Irion County, TX Tom Green County, TX	0.8380

CBSA Code	Urban Area (Constituent Counties)	Wage Index
41700	San Antonio, TX	0.9365
	Atascosa County, TX	
	Bandera County, TX	
	Bexar County, TX	
	Comal County, TX	
	Guadalupe County, TX	
	Kendall County, TX	
	Medina County, TX	
	Wilson County, TX	
41740	San Diego-Carlsbad-San Marcos, CA	1.2440
	San Diego County, CA	
41780	Sandusky, OH	0.9411
	Erie County, OH	
41884	San Francisco-San Mateo-Redwood City, CA	1.6887
	Marin County, CA	
	San Francisco County, CA	
	San Mateo County, CA	
41900	San Germán-Cabo Rojo, PR	0.6876
	Cabo Rojo Municipio, PR	
	Lajas Municipio, PR	
	Sabana Grande Municipio, PR	
	San Germán Municipio, PR	
41940	San Jose-Sunnyvale-Santa Clara, CA	1.7348
	San Benito County, CA	
	Santa Clara County, CA	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
41980	San Juan-Caguas-Guaynabo, PR	0.6876
	Aguas Buenas Municipio, PR	
	Aibonito Municipio, PR	
	Arecibo Municipio, PR	
	Barceloneta Municipio, PR	
	Barranquitas Municipio, PR	
	Bayamón Municipio, PR	
	Caguas Municipio, PR	
	Camuy Municipio, PR	
	Canóvanas Municipio, PR	
	Carolina Municipio, PR	
	Cataño Municipio, PR	
	Cayey Municipio, PR	
	Ciales Municipio, PR	
	Cidra Municipio, PR	
	Comerío Municipio, PR	
	Corozal Municipio, PR	
	Dorado Municipio, PR	
	Florida Municipio, PR	
	Guaynabo Municipio, PR	
	Gurabo Municipio, PR	
	Hatillo Municipio, PR	
	Humacao Municipio, PR	
	Juncos Municipio, PR	
	Las Piedras Municipio, PR	
	Loíza Municipio, PR	
	Manatí Municipio, PR	
	Maunabo Municipio, PR	
	Morovis Municipio, PR	
	Naguabo Municipio, PR	
	Naranjito Municipio, PR	
	Orocovis Municipio, PR	
	Quebradillas Municipio, PR	
	Río Grande Municipio, PR	
	San Juan Municipio, PR	
	San Lorenzo Municipio, PR	
	Toa Alta Municipio, PR	
	Toa Baja Municipio, PR	
	Trujillo Alto Municipio, PR	
	Vega Alta Municipio, PR	
	Vega Baja Municipio, PR	
	Yabucoa Municipio, PR	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
42020	San Luis Obispo-Paso Robles, CA San Luis Obispo County, CA	1.3288
42044	Santa Ana-Anaheim-Irvine, CA Orange County, CA	1.2670
42060	Santa Barbara-Santa Maria-Goleta, CA Santa Barbara County, CA	1.3047
42100	Santa Cruz-Watsonville, CA Santa Cruz County, CA	1.7719
42140	Santa Fe, NM Santa Fe County, NM	1.1324
42220	Santa Rosa-Petaluma, CA Sonoma County, CA	1.6835
42340	Savannah, GA Bryan County, GA Chatham County, GA Effingham County, GA	0.9575
42540	Scranton--Wilkes-Barre, PA Lackawanna County, PA Luzerne County, PA Wyoming County, PA	0.8867
42644	Seattle-Bellevue-Everett, WA King County, WA Snohomish County, WA	1.2258
42680	Sebastian-Vero Beach, FL Indian River County, FL	0.9912
43100	Sheboygan, WI Sheboygan County, WI	0.9705
43300	Sherman-Denison, TX Grayson County, TX	0.8535
43340	Shreveport-Bossier City, LA Bossier Parish, LA Caddo Parish, LA De Soto Parish, LA	0.8877
43580	Sioux City, IA-NE-SD Woodbury County, IA Dakota County, NE Dixon County, NE Union County, SD	0.9630
43620	Sioux Falls, SD Lincoln County, SD McCook County, SD Minnehaha County, SD Turner County, SD	0.9511
43780	South Bend-Mishawaka, IN-MI St. Joseph County, IN Cass County, MI	1.0260
43900	Spartanburg, SC Spartanburg County, SC	0.9891
44060	Spokane, WA Spokane County, WA	1.1058
44100	Springfield, IL Menard County, IL Sangamon County, IL	1.0107
44140	Springfield, MA Franklin County, MA Hampden County, MA Hampshire County, MA	1.0985
44180	Springfield, MO Christian County, MO Dallas County, MO Greene County, MO Polk County, MO Webster County, MO	0.8524
44220	Springfield, OH Clark County, OH	0.9736
44300	State College, PA Centre County, PA	0.9631
44700	Stockton, CA San Joaquin County, CA	1.3018
44940	Sumter, SC Sumter County, SC	0.8631
45060	Syracuse, NY Madison County, NY Onondaga County, NY Oswego County, NY	1.0357
45104	Tacoma, WA Pierce County, WA	1.1855

CBSA Code	Urban Area (Constituent Counties)	Wage Index
45220	Tallahassee, FL Gadsden County, FL Jefferson County, FL Leon County, FL Wakulla County, FL	0.8901
45300	Tampa-St. Petersburg-Clearwater, FL Hernando County, FL Hillsborough County, FL Pasco County, FL Pinellas County, FL	0.9510
45460	Terre Haute, IN Clay County, IN Sullivan County, IN Vermillion County, IN Vigo County, IN	0.9486
45500	Texarkana, TX-Texarkana, AR Miller County, AR Bowie County, TX	0.8591
45780	Toledo, OH Fulton County, OH Lucas County, OH Ottawa County, OH Wood County, OH	1.0102
45820	Topeka, KS Jackson County, KS Jefferson County, KS Osage County, KS Shawnee County, KS Wabaunsee County, KS	0.9350
45940	Trenton-Ewing, NJ Mercer County, NJ	1.1172
46060	Tucson, AZ Pima County, AZ	1.0065
46140	Tulsa, OK Creek County, OK Okmulgee County, OK Osage County, OK Pawnee County, OK Rogers County, OK Tulsa County, OK Wagoner County, OK	0.9172
46220	Tuscaloosa, AL Greene County, AL Hale County, AL Tuscaloosa County, AL	0.9210
46340	Tyler, TX Smith County, TX	0.8802
46540	Utica-Rome, NY Herkimer County, NY Oneida County, NY	0.8984
46660	Valdosta, GA Brooks County, GA Echols County, GA Lanier County, GA Lowndes County, GA	0.8412
46700	Vallejo-Fairfield, CA Solano County, CA	1.5813
47020	Victoria, TX Calhoun County, TX Goliad County, TX Victoria County, TX	0.8529
47220	Vineland-Millville-Bridgeton, NJ Cumberland County, NJ	1.0807
47260	Virginia Beach-Norfolk-Newport News, VA-NC Currituck County, NC Gloucester County, VA Isle of Wight County, VA James City County, VA Mathews County, VA Surry County, VA York County, VA Chesapeake City, VA Hampton City, VA Newport News City, VA Norfolk City, VA Poquoson City, VA Portsmouth City, VA Suffolk City, VA Virginia Beach City, VA Williamsburg City, VA	0.9844
47300	Visalia-Porterville, CA Tulare County, CA	1.0823

CBSA Code	Urban Area (Constituent Counties)	Wage Index
47380	Waco, TX McLennan County, TX	0.8869
47580	Warner Robins, GA Houston County, GA	0.9269
47644	Warren-Troy-Farmington Hills, MI Lapeer County, MI Livingston County, MI Macomb County, MI Oakland County, MI St. Clair County, MI	1.0394
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV District of Columbia, DC Calvert County, MD Charles County, MD Prince George's County, MD Arlington County, VA Clarke County, VA Fairfax County, VA Fauquier County, VA Loudoun County, VA Prince William County, VA Spotsylvania County, VA Stafford County, VA Warren County, VA Alexandria City, VA Fairfax City, VA Falls Church City, VA Fredericksburg City, VA Manassas City, VA Manassas Park City, VA Jefferson County, WV	1.1521
47940	Waterloo-Cedar Falls, IA Black Hawk County, IA Bremer County, IA Grundy County, IA	0.9020
48140	Wausau, WI Marathon County, WI	0.9996
48260	Weirton-Steubenville, WV-OH Jefferson County, OH Brooke County, WV Hancock County, WV	0.7802
48300	Wenatchee, WA Chelan County, WA Douglas County, WA	1.0291
48424	West Palm Beach-Boca Raton-Boynton Beach, FL Palm Beach County, FL	1.0460
48540	Wheeling, WV-OH Belmont County, OH Marshall County, WV Ohio County, WV	0.7274
48620	Wichita, KS Butler County, KS Harvey County, KS Sedgwick County, KS Sumner County, KS	0.9498
48660	Wichita Falls, TX Archer County, TX Clay County, TX Wichita County, TX	0.9738
48700	Williamsport, PA Lycoming County, PA	0.8341
48864	Wilmington, DE-MD-NJ New Castle County, DE Cecil County, MD Salem County, NJ	1.1169
48900	Wilmington, NC Brunswick County, NC New Hanover County, NC Pender County, NC	0.9515
49020	Winchester, VA-WV Frederick County, VA Winchester City, VA Hampshire County, WV	1.0352
49180	Winston-Salem, NC Davie County, NC Forsyth County, NC Stokes County, NC Yadkin County, NC	0.9460
49340	Worcester, MA Worcester County, MA	1.1741
49420	Yakima, WA Yakima County, WA	1.0534

CBSA Code	Urban Area (Constituent Counties)	Wage Index
49500	Yauco, PR Guánica Municipio, PR Guayanilla Municipio, PR Peñuelas Municipio, PR Yauco Municipio, PR	0.6876
49620	York-Hanover, PA York County, PA	0.9847
49660	Youngstown-Warren-Boardman, OH-PA Mahoning County, OH Trumbull County, OH Mercer County, PA	0.9114
49700	Yuba City, CA	1.1743
49740	Yuma, AZ Yuma County, AZ	0.9682

ADDENDUM G: CY 2009 ESRD Wage Index Based on CBSA Labor Market Areas for Rural Areas

CBSA Code	Nonurban Area	Wage Index
1	Alabama	0.7760
2	Alaska	1.2356
3	Arizona	0.9310
4	Arkansas	0.7769
5	California	1.2551
6	Colorado	1.0513
7	Connecticut	1.1849
8	Delaware	1.0493
10	Florida	0.9070
11	Georgia	0.8077
12	Hawaii	1.1767
13	Idaho	0.8188
14	Illinois	0.8784
15	Indiana	0.9010
16	Iowa	0.9230
17	Kansas	0.8651
18	Kentucky	0.8262
19	Louisiana	0.8058
20	Maine	0.9084
21	Maryland	0.9668
22	Massachusetts	1.2389
23	Michigan	0.9290
24	Minnesota	0.9714
25	Mississippi	0.8088
26	Missouri	0.8144
27	Montana	0.8912
28	Nebraska	0.9104
29	Nevada	1.0244
30	New Hampshire	1.0537
31	New Jersey	------
32	New Mexico	0.9464
33	New York	0.8739
34	North Carolina	0.9029

CBSA Code	Nonurban Area	Wage Index
35	North Dakota	0.8243
36	Ohio	0.8996
37	Oklahoma	0.8104
38	Oregon	1.0842
39	Pennsylvania	0.8765
40	Puerto Rico	0.6876
41	Rhode Island[1]	------
42	South Carolina	0.8863
43	South Dakota	0.8900
44	Tennessee	0.8270
45	Texas	0.8223
46	Utah	0.8856
47	Vermont	1.0338
48	Virgin Islands	0.7853
49	Virginia	0.8332
50	Washington	1.0825
51	West Virginia	0.7832
52	Wisconsin	0.9744
53	Wyoming	1.0096

[1] All counties within the State are classified as urban.

[FR Doc. E9–15835 Filed 7–1–09; 11:15 am]
BILLING CODE 4120–01–C

Federal Register

Monday,
July 13, 2009

Part III

Department of Commerce

National Oceanic and Atmospheric Administration

50 CFR Part 218

Taking and Importing Marine Mammals; Navy Training Activities Conducted Within the Northwest Training Range Complex; Proposed Rule

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 218

[Docket No. 0906101030–91038–01]

RIN 0648–AX88

Taking and Importing Marine Mammals; Navy Training Activities Conducted Within the Northwest Training Range Complex

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Proposed rule; request for comments.

SUMMARY: NMFS has received a request from the U.S. Navy (Navy) for authorization to take marine mammals incidental to training activities conducted in the Northwest Training Range Complex (NWTRC), off the coasts of Washington, Oregon, and northern California, for the period of February 2010 through February 2015 (updated from initial request for October 2009 through September 2014). Pursuant to the Marine Mammal Protection Act (MMPA), NMFS is proposing regulations to govern that take and requesting information, suggestions, and comments on these proposed regulations.

DATES: Comments and information must be received no later than August 12, 2009.

ADDRESSES: You may submit comments, identified by 0648–AX88, by any one of the following methods:

- *Electronic Submissions:* Submit all electronic public comments via the Federal eRulemaking Portal *http://www.regulations.gov*.
- Hand delivery or mailing of paper, disk, or CD–ROM comments should be addressed to Michael Payne, Chief, Permits, Conservation and Education Division, Office of Protected Resources, National Marine Fisheries Service, 1315 East-West Highway, Silver Spring, MD 20910–3225.

Instructions: All comments received are a part of the public record and will generally be posted to *http://www.regulations.gov* without change. All Personal Identifying Information (for example, name, address, *etc.*) voluntarily submitted by the commenter may be publicly accessible. Do not submit Confidential Business Information or otherwise sensitive or protected information.

NMFS will accept anonymous comments (enter N/A in the required fields if you wish to remain anonymous). Attachments to electronic comments will be accepted in Microsoft Word, Excel, WordPerfect, or Adobe PDF file formats only.

FOR FURTHER INFORMATION CONTACT: Jolie Harrison, Office of Protected Resources, NMFS, (301) 713–2289, ext. 166.

SUPPLEMENTARY INFORMATION:

Availability

A copy of the Navy's application may be obtained by writing to the address specified above (*See* **ADDRESSES**), telephoning the contact listed above (*see* **FOR FURTHER INFORMATION CONTACT**), or visiting the Internet at: *http://www.nmfs.noaa.gov/pr/permits/incidental.htm#applications*. The Navy's Draft Environmental Impact Statement (DEIS) for NWTRC was published on December 29 2008, and may be viewed at *http://www.nmfs.noaa.gov/pr/permits/incidental.htm#applications*. NMFS is participating in the development of the Navy's EIS as a cooperating agency under NEPA.

Background

Sections 101(a)(5)(A) and (D) of the MMPA (16 U.S.C. 1361 *et seq.*) direct the Secretary of Commerce (Secretary) to allow, upon request, the incidental, but not intentional taking of marine mammals by U.S. citizens who engage in a specified activity (other than commercial fishing) during periods of not more than five consecutive years each if certain findings are made and regulations are issued or, if the taking is limited to harassment, notice of a proposed authorization is provided to the public for review.

Authorization shall be granted if NMFS finds that the taking will have a negligible impact on the species or stock(s), will not have an unmitigable adverse impact on the availability of the species or stock(s) for subsistence uses, and if the permissible methods of taking and requirements pertaining to the mitigation, monitoring and reporting of such taking are set forth. NMFS has defined ''negligible impact'' in 50 CFR 216.103 as:

> ''An impact resulting from the specified activity that cannot be reasonably expected to, and is not reasonably likely to, adversely affect the species or stock through effects on annual rates of recruitment or survival.''

The National Defense Authorization Act of 2004 (NDAA) (Pub. L. 108–136) modified the MMPA by removing the ''small numbers'' and ''specified geographical region'' limitations and amended the definition of ''harassment'' as it applies to a ''military readiness activity'' to read as follows (Section 3(18)(B) of the MMPA):

> (i) Any act that injures or has the significant potential to injure a marine mammal or marine mammal stock in the wild [Level A Harassment]; or
>
> (ii) Any act that disturbs or is likely to disturb a marine mammal or marine mammal stock in the wild by causing disruption of natural behavioral patterns, including, but not limited to, migration, surfacing, nursing, breeding, feeding, or sheltering, to a point where such behavioral patterns are abandoned or significantly altered [Level B Harassment].

In January 2009, the Council on Environmental Quality requested that NOAA conduct a comprehensive review of the Navy's mitigation measures applicable to the use of sonar in it's training activities.

Summary of Request

In September 2008, NMFS received an application from the Navy requesting authorization for the take of individuals of 26 species of marine mammals incidental to upcoming Navy training activities to be conducted within the NWTRC, which extends west to 250 nautical miles (nm) (463 kilometers [km]) beyond the coast of Northern California, Oregon, and Washington and east to Idaho and encompasses 122,400 nm^2 (420,163 km^2) of surface/subsurface ocean operating areas. These training activities are military readiness activities under the provisions of the NDAA. The Navy states, and NMFS concurs, that these military readiness activities may incidentally take marine mammals present within the NWTRC by exposing them to sound from mid-frequency or high frequency active sonar (MFAS/HFAS) or underwater detonations. The Navy requests authorization to take individuals of 26 species of marine mammals by Level B Harassment and 14 individuals of 10 species by Level A Harassment. The Navy's model, which did not factor in any potential benefits of mitigation measures, predicted that 14 individual marine mammals would be exposed to levels of sound or pressure that would result in injury; thus, NMFS is proposing to authorize the take, by Level A Harassment of 14 individuals. However, NMFS and the Navy have determined preliminarily that injury can be avoided through the implementation of the Navy's proposed mitigation measures. NMFS neither anticipates, nor does it propose to authorize mortality of marine mammals incidental to naval exercises in the NWTRC.

Background of Request

The Navy's mission is to maintain, train, and equip combat-ready naval forces capable of winning wars, deterring aggression, and maintaining freedom of the seas. Section 5062 of Title 10 of the United States Code directs the Chief of Naval Operations to train all naval forces for combat. The Chief of Naval Operations meets that direction, in part, by conducting at-sea training exercises and ensuring naval forces have access to ranges, operating areas (OPAREAs) and airspace where they can develop and maintain skills for wartime missions and conduct research, development, testing, and evaluation (RDT&E) of naval weapons systems.

The proposed action would result in selectively focused, but critical enhancements and increases in training that are necessary for the Navy to maintain a state of military readiness commensurate with the national defense mission. The Navy proposes to implement actions within the NWTRC to:

- Conduct training and Unmanned Aerial Systems (UAS) RDT&E activities of the same types as currently conducted, but also;
- Increase training activities from current levels as necessary in support of the Fleet Response Training Plan (FRTP);
- Accommodate force structure changes (new platforms and weapons systems); and
- Implement range enhancements associated with the NWTRC.

The proposed action would result in the following increases (above those conducted in previous years, *i.e.*, the No Action Alternative in the Navy's DEIS) in activities:

- *Antisubmarine Warfare*—10% increase.
- *Gunnery Exercises*—100% increase (increased from 90 to 176 events).
- *Bombing Exercises*—25% increase (increased from 24 to 30 sorties).
- *Sinking Exercises*—100% increase (increased from 1 to 2 exercises).

Overview of the NWTRC

The U.S. Navy has been training and operating in the area now defined as the NWTRC for over 60 years. The NWTRC includes ranges and airspace that extend west to 250 nm (463 km) beyond the coast of Northern California, Oregon, and Washington and east to Idaho. The components of the NWTRC encompass 122,461 nm^2 (420,163 km^2) of surface/subsurface ocean operating areas (OPAREAs), 46,048 nm^2 (157,928 km^2) of special use airspace (SUA), and 875 acres (354 hectares) of land. For range management and scheduling purposes, the NWTRC is divided into numerous sub-component ranges or training areas used to conduct training and RDT&E of military hardware, personnel, tactics, munitions, explosives, and electronic combat systems, as described in detail in the NWTRC DEIS. As the take of marine mammals is inherently tied to the surface/subsurface OPAREAs of the NWTRC, only those areas are discussed in more detail below.

The LOA application includes graphics (Figures 1–1, 2–1, and 2–2) that depict the sea, undersea, and air spaces used by the Navy. To aid in the description of the range complexes that will be addressed in this proposed rule, the ranges are divided into three major geographic and functional subdivisions. Each of the depicted individual ranges falls into one of these three major range subdivisions:

The Offshore Area—The Pacific Northwest (PACNW) OPAREA (same footprint as Offshore Area) serves as maneuver water space for ships and submarines to conduct training and to use as transit lanes. It extends from the Strait of Juan de Fuca in the north, to approximately 50 nm (93 km) south of Eureka, California in the south, and from the coast line of Washington, Oregon, and California westward to 130° W. longitude. The PACNW OPAREA is approximately 510 nm (945 km) in length from the northern boundary to the southern boundary, and 250 nm (463 km) from the coastline to the western boundary at 130° W longitude. Total surface area of the PACNW OPAREA is 122,400 nm^2 (420,163 km^2).

Commander Submarine Force, U.S. Pacific Fleet (COMSUBPAC) Pearl Harbor manages this water space as transit lanes for U.S. submarines. While the sea space is ample for all levels of Navy training, no infrastructure is currently in place to support training. There are no dedicated training frequencies, no permanent instrumentation, no meteorological and oceanographic activities (METOC) system, and no Opposition Forces (OPFOR) or Electronic Combat (EC) target systems. In this region of the Pacific Ocean, storms and high sea states can create challenges to surface ship training between October and April. In addition, strong undersea currents in the PACNW make it difficult to place permanent bottom-mounted instrumentation such as hydrophones.

The Offshore Area undersea space lies beneath the PACNW OPAREA as described above. The bathymetry chart depicts a 100-fathom (182-m) curve parallel to the coastline approximately 12 nm (22 km) to sea, and in places 20 nm (37 km) out to sea. The area of deeper water of more than 100 fathoms (182 m) is calculated to be approximately 115,800 nm^2 (397,194 km^2), while the shallow water area of less than 100 fathoms (600 ft, 182 m) is all near shore and amounts to approximately 6,600 nm^2 (22,638 km^2).

The Inshore Area—This area includes all sea and undersea ranges and OPAREAs inland of the coastline, including Puget Sound. This area is composed of approximately 61 nm^2 of surface and subsurface area. NWTRC Inshore Areas include land ranges, airspace, and two surface/subsurface restricted areas—Navy 7 and 3. Activities conducted in each of these areas are not expected to take marine mammals, as defined by the MMPA and therefore, and will not be discussed further in this proposed rule. Also included in the Inshore Area, Explosive Ordnance Disposal (EOD) Ranges are land, sea, and undersea ranges used by NSW and EOD forces specifically for EOD training and are composed of approximately 0.4 nm^2 of surface and subsurface area within the area identified as the Inshore Area. EOD units located in the NWTRC conduct underwater detonations as part of mine countermeasure training. This training is conducted at one of three locations: Crescent Harbor Underwater EOD Range, offshore from the Seaplane Base at Naval Air Station Whidbey Island; at the Floral Point Underwater EOD Range, located in Hood Canal near NAVBASE Kitsap-Bangor; and the Indian Island Underwater EOD Range, adjacent to Indian Island.

Description of Specified Activities

As mentioned above, the Navy has requested MMPA authorization to take marine mammals incidental to training activities in the NWTRC that would result in the generation of sound or pressure waves in the water at or above levels that NMFS has determined will likely result in take (see Acoustic Take Criteria Section), either through the use of MFAS/HFAS or the detonation of explosives in the water. These activities are discussed in the subsections below. In addition to use of active sonar sources and explosives, these activities include the operation and movement of vessels that are necessary to conduct the training, and the effects of this part of the activities are also analyzed in this document.

The Navy's application also briefly summarizes Anti-Air Warfare Training, Naval Special Warfare Training and Support Operations; however, these activities are primarily land and air based and do not utilize sound sources

or explosives for the portions that are in the water and, therefore, no take of marine mammals is anticipated from these activities and they are not discussed further.

Activities Utilizing Active Sonar Sources

For the NWTRC, the training activities that utilize active tactical sonar sources fall primarily into the category of Anti-submarine Warfare (ASW) exercises (MFAS/HFAS is also used in the mine avoidance exercises, which are considered Mine Warfare Training (MIW) activities; however, it is in such a small amount that impacts to marine mammals are minimal). This section includes a description of ASW, the active acoustic devices used in ASW exercises, and the exercise types in which these acoustic sources are used. Of note, the use of MFAS/HFAS in the NWTRC is minimal as compared to previous rules issued by NMFS (approximately 110 hours annual use of the most powerful surface vessel sonar versus approximately 2,500 hours annual use of AN/SQS–53C and AN/SQS–56C sonar in the Southern California Range Complex), does not include major exercises that involve the use of more than one surface vessel MFAS (AN/SQS–53C or AN/SQS–56C) at a time, and will not occur in the inshore area (*i.e.*, inland from the mouth of the Strait of Juan de Fuca).

ASW Training and Active Sonar

ASW involves helicopter and sea control aircraft, ships, and submarines, operating alone or in combination, to locate, track, and neutralize submarines. Various types of active and passive sonars are used by the Navy to determine water depth, locate mines, and identify, track, and target submarines. Passive sonar ''listens'' for sound waves by using underwater microphones, called hydrophones, which receive, amplify and process underwater sounds. No sound is introduced into the water when using passive sonar. Passive sonar can indicate the presence, character and movement of submarines. However, passive sonar provides only a bearing (direction) to a sound-emitting source; it does not provide an accurate range (distance) to the source. Also, passive sonar relies on the underwater target itself to provide sufficient sound to be detected by hydrophones. Active sonar is needed to locate objects that emit little or no noise (such as mines or diesel-electric submarines operating in electric mode) and to establish both bearing and range to the detected contact.

Active sonar transmits pulses of sound that travel through the water, reflect off objects and return to a receiver. By knowing the speed of sound in water and the time taken for the sound wave to travel to the object and back, active sonar systems can quickly calculate direction and distance from the sonar platform to the underwater object. There are three types of active sonar: low frequency, mid-frequency, and high-frequency.

LFA sonar is not presently utilized in the NWTRC, and is not part of the Proposed Action.

MFAS, as defined in the Navy's NWTRC LOA application, operates between 1 and 10 kHz, with detection ranges up to 10 nm (19 km). Because of this detection ranging capability, MFAS is the Navy's primary tool for conducting ASW. Many ASW experiments and exercises have demonstrated that this improved capability for long range detection of adversary submarines before they are able to conduct an attack is essential to U.S. ship survivability. Today, ASW is the Navy's number one war-fighting priority. Navies across the world utilize modern, quiet, diesel-electric submarines that pose the primary threat to the U.S. Navy's ability to perform a number of critical missions. Extensive training is necessary if Sailors, ships, and strike groups are to gain proficiency in using MFAS. If a strike group does not demonstrate MFAS proficiency, it cannot be certified as combat ready.

HFAS, as defined in the Navy's NWTRC LOA application, operates at frequencies greater than 10 kilohertz (kHz). At higher acoustic frequencies, sound rapidly dissipates in the ocean environment, resulting in short detection ranges, typically less than five nm (9 km). High-frequency sonar is used primarily for determining water depth, hunting mines and guiding torpedoes.

Acoustic Sources Used for ASW Exercises in the NWTRC

Modern sonar technology has developed a multitude of sonar sensor and processing systems. In concept, the simplest active sonars emit omni-directional pulses (''pings'') and time the arrival of the reflected echoes from the target object to determine range. More sophisticated active sonar emits an omni-directional ping and then rapidly scans a steered receiving beam to provide directional, as well as range, information. More advanced active sonars transmit multiple preformed beams, listening to echoes from several directions simultaneously and providing efficient detection of both direction and range. The types of active sonar sources employed during ASW active sonar training exercises in the NWTRC are identified in Table 1.

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Sonar Sources	Frequency (kHz)	Source Level (dB) re 1 µPa @ 1 m	Emission Spacing (m)*	Vertical Directivity	Horizontal Directivity	Associated Platform	System Description	Annual Amount	Unit
AN/SQS-53C	3.5	235	154	Omni	240° forward-looking	Cruiser (CG) and Destroyer (DDG) hull mounted sonar	ASW search, detection, & localization (approximately 120 pings per hour)	43	Hours
AN/SQS-56C	7.5	225	129	13°	30°	Frigate (FFG) hullmounted sonar	ASW search, detection, & localization (approximately 120 pings per hour)	65	Hours
AN/BQS-15	Classifed (HF)	Classified				Submarine (SSN) hullmounted sonar	Submarine navigation and mine detection sonar	42	Hours
AN/SSQ-62 DICASS (sonobuoy, tonal)	8	201	450	Omni	Omni	Helicopter and maritime patrol aircraft (P3 and P8 MPA) dropped sonobuoy	Remotely commanded expendable sonar-equipped buoy (approximately 12 pings per use, 30 secs between pings, 8 buoys per hour)	886	Buoys
MK-48 torpedo sonar	Classified (>10)	Classified	144	Omni	Omni	Submarine (SSN) launched torpedo (used during SINKEX)	Recoverable and non-explosive exercise torpedo; sonar is active approximately 15 min per torpedo run	2	Torpedoes
AN/SSQ-110A (IEER)	Classified (impulsive, broadband)	Classified	n/a	Omni	Omni	MPA deployed	ASW system consists of explosive acoustic source buoy (contains two 4.1 lb charges) and expendable passive receiver sonobuoy	149	Buoys
AN/SSQ-125 (AEER)	MF	Classified	n/a	Omni	Omni	MPA deployed	ASW system consists of active sonobuoy and expendable passive receiver sonobuoy	Replaces SSQ-110A, same effects as SSQ-62	
Range Pingers	12.9	194				Ships, submarines, and ASW targets when ASW TRACKEX training is conducted on the PUTR	1-3 pingers used in each ASW exercise, average of 3 hours each during PUTR operational days	180	Hours
PUTR Uplink	8.8., 17, or 40	190			180 upward looking	Portable Undersea Tracking Range, deployed on ocean floor	Used 10 days per month June-Aug, 5 hours/day. Deployed in at least 3nm from shore in 300-12000 ft of water	150	Hours

Table 1. Active sonar sources in the NWTRC and parameters used for modeling them. Many of the actual parameters and capabilities of these sonars are classified. Parameters used for modeling were derived to be as representative as possible. When, however, there were a wide range of potential modeling values, a nominal parameter likely to result in the most impact was used so that the model would err towards overestimation.
*Spacing means distance between pings at the nominal speed
CG – Guided Missile Cruiser; DDG – Guided Missile Destroyer; DICASS – Directional Command-Activated Sonobuoy System; FFG – Fast Frigate; HF – High-Frequency; MF – Mid-Frequency.

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ASW sonar systems are deployed from certain classes of surface ships, submarines, and fixed-wing maritime patrol aircraft (MPA). Maritime patrol aircraft is a category of fixed-wing aircraft that includes the current P–3C Orion, and the future P–8 Poseidon multimission maritime aircraft. No ASW helicopters train in the NWTRC. The

surface ships used are typically equipped with hull-mounted sonars (passive and active) for the detection of submarines. Fixed-wing MPA are used to deploy both active and passive sonobuoys to assist in locating and tracking submarines or ASW targets during the exercise. Submarines are equipped with passive sonar sensors used to locate and prosecute other submarines and/or surface ships during the exercise. The platforms used in ASW exercises are identified below.

Surface Ship Sonars—A variety of surface ships participate in training events. Of the ships that operate in the NWTRC, only two classes employ MFAS: the Fast Frigate (FFG) and the Guided Missile Destroyer (DDG). These two classes of ship are equipped with active as well as passive tactical sonars for mine avoidance and submarine detection and tracking. DDG class ships are equipped with the AN/SQS–53C sonar system (the most powerful system), with a nominal source level of 235 decibels (dB) re 1 µPa @ 1 m. The FFG class ship uses the SQS–56 sonar system, with a nominal source level of 225 decibels (dB) re 1 µPa @ 1 m. Sonar ping transmission durations were modeled as lasting 1 second per ping and omni-directional, which is a conservative assumption that will overestimate potential effects. Actual ping durations will be less than 1 second. The AN/SQS–53C hull-mounted sonar transmits at a center frequency of 3.5 kHz. The SQS–56 transmits at a center frequency of 7.5 kHz. Details concerning the tactical use of specific frequencies and the repetition rate for the sonar pings is classified but was modeled based on the required tactical training setting.

Submarine Sonars—Submarine active sonars are not used for ASW training in the NWTRC. However, the AN/BQS–15 sonar would be used for mine detection training. The AN/BQS–15, installed on guided missile nuclear submarines (SSGN) and fast attack nuclear submarines (SSN), uses high frequency (> 10 kHz) active sonar to locate mine shapes. A total of seven mine avoidance exercises would take place annually in the NWTRC. Each exercise would last six hours, for a total of 42 hours annually.

Aircraft Sonar Systems—Sonobuoys are the only aircraft sonar systems that would operate in the NWTRC. Sonobuoys are deployed by MPAs and are expendable devices used for the detection of submarines. Most sonobuoys are passive, but some can generate active acoustic signals, as well as listen passively. During ASW training, these systems' active modes are used for localization of contacts and are not typically used in primary search capacity. The AN/SSQ–62 Directional Command Activated Sonobuoy System (DICASS) is the only MFAS sonobuoy used in the NWTRC. Because no ASW helicopters train in the NWTRC, no dipping sonar system is carried forward for any further analysis of effects.

Extended Echo Ranging and Improved Extended Echo Ranging (EER/IEER) Systems—EER/IEER are airborne ASW systems used to conduct ''large area'' searches for submarines. These systems are made up of airborne avionics ASW acoustic processing and sonobuoy types that are deployed in pairs. The EER/IEER System's active sonobuoy component, the AN/SSQ–110A Sonobuoy, generates an explosive sound impulse and a passive sonobuoy (ADAR, AN/SSQ–101A) would ''listen'' for the return echo that has been bounced off the surface of a submarine. These sonobuoys are designed to provide underwater acoustic data necessary for naval aircrews to quickly and accurately detect submerged submarines. The sonobuoy pairs are dropped from a maritime patrol aircraft into the ocean in a predetermined pattern with a few buoys covering a very large area. The AN/SSQ–110A Sonobuoy Series is an expendable and commandable sonobuoy. Upon command from the aircraft, the explosive charge would detonate, creating the sound impulse. Within the sonobuoy pattern, only one detonation is commanded at a time. Twelve to twenty SSQ–110A source sonobuoys are used in a typical exercise. Both charges of each sonobuoy would be detonated during the course of the training, either tactically to locate the submarine, or when the sonobuoys are commanded to scuttle at the conclusion of the exercise. The AN/SSQ–110A is listed in this table because it functions like a sonar ping, however, the source creates an explosive detonation and its effects are considered in the underwater explosive section.

Advanced Extended Echo Ranging (AEER) System—The proposed AEER system is operationally similar to the existing EER/IEER system. The AEER system will use the same ADAR sonobuoy (SSQ–101A) as the acoustic receiver and will be used for a large area ASW search capability in both shallow and deep water. However, instead of using an explosive AN/SQS–110A as an impulsive source for the active acoustic wave, the AEER system will use a battery powered (electronic) source for the AN/SSQ 125 sonobuoy. The output and operational parameters for the AN/SSQ–125 sonobuoy (source levels, frequency, wave forms, *etc.*) are classified. However, this sonobuoy is intended to replace the EER/IEER's use of explosives and is scheduled to enter the fleet in 2011. Acoustic impact analysis for the AN/SSQ–125 in this document assumes a similar per-buoy effect as that modeled for the DICASS sonobuoy. For purposes of analysis, replacement of the EER/IEER system by the AEER system will be assumed to occur at 25% per year as follows: 2011—25% replacement; 2012—50% replacement; 2013—75% replacement; 2014—100% replacement with no further use of the EER/IEER system beginning in 2015 and beyond.

Torpedoes—Torpedoes are the primary ASW weapon used by surface ships, aircraft, and submarines. The guidance systems of these weapons can be autonomous or electronically controlled from the launching platform through an attached wire. The autonomous guidance systems are acoustically based. They operate either passively, exploiting the emitted sound energy by the target, or actively, ensonifying the target and using the received echoes for guidance. The MK–48 submarine-launched torpedo, used in its anti-surface ship mode, was modeled for active sonar transmissions in Sinking Exercises conducted within the NWTRC.

Portable Undersea Tracking Range—The Portable Undersea Tracking Range (PUTR) has been developed to support ASW training in areas where the ocean depth is between 300 ft and 12,000 ft and at least 3 nm from land. This proposed project would temporarily instrument 25-square-mile or smaller areas on the seafloor, and would provide high fidelity feedback and scoring of crew performance during ASW training activities. When training is complete, the PUTR equipment would be recovered. All of the potential PUTR areas have been used for ASW training for decades.

No on-shore construction would take place. Seven electronics packages, each approximately 3 ft long by 2 ft in diameter, would be temporarily installed on the seafloor by a range boat, in water depths greater than 600 ft. The anchors used to keep the electronics packages on the seafloor would be either concrete or sand bags, approximately 1.5 ft-by-1.5 ft and 300 pounds. Each package consists of a hydrophone that receives pinger signals, and a transducer that sends an acoustic ''uplink'' of locating data to the range boat. The uplink signal is transmitted at 8.8 kilohertz (kHz), 17 kHz, or 40 kHz, at a source level of 190 decibels (dB). The Portable Undersea Tracking Range

system also incorporates an underwater voice capability that transmits at 8–11 kHz and a source level of 190 dB. Each of these packages is powered by a D cell alkaline battery. After the end of the battery life, the electronic packages would be recovered and the anchors would remain on the seafloor. The Navy proposes to deploy this system for 3 months of the year (approximately June–August), and to conduct TRACKEX activities for 10 days per month in an area beyond 3 nm from shore. During each of the 30 days of annual operation, the PUTR would be in use for 5 hours each day. No additional ASW activity is proposed as a result of PUTR use. Operation of this range requires that underwater participants transmit their locations via pingers and that the receiving transducers transmit that information the range boat via the Uplink transmitter (*see* ''Range Tracking Pingers'' and uplink transmitter ''below'').

Range Tracking Pingers—MK–84 range tracking pingers would be used on ships, submarines, and ASW targets when ASW TRACKEX training is conducted on the PUTR. The MK–84 pinger generates a 12.93 kHz sine wave in pulses with a maximum duty cycle of 30 milliseconds (3% duty cycle) and has a design power of 194 dB re 1 micro-Pascal at 1 meter. Although the specific exercise, and number and type of participants will determine the number of pingers in use at any time, a minimum of one and a maximum of three pingers would be used for each ASW training activity. On average, two pingers would be in use for 3 hours each during PUTR operational days.

Uplink Transmitters—Each package consists of a hydrophone that receives pinger signals, and a transducer that sends an acoustic ''uplink'' of locating data to the range boat. The uplink signal is transmitted at 8.8 kilohertz (kHz), 17 kHz, or 40 kHz, at a source level of 190 decibels (dB). The Portable Undersea Tracking Range system also incorporates an underwater voice capability that transmits at 8–11 kHz and a source level of 190 dB. Under the proposed action, the uplink transmitters would operate 30 days per year, for 5 hours each day of use. The total time of use would be 150 hours annually.

Exercises Utilizing MFAS in the NWTRC

ASW Tracking Exercises are the exercises that primarily utilize MFAS and HFAS sources in the NWTRC, although Mine Avoidance MIW exercises also utilize a less powerful HFAS source. ASW Tracking Exercise (TRACKEX) trains aircraft, ship, and submarine crews in tactics, techniques, and procedures for search, detection, localization, and tracking of submarines with the goal of determining a firing solution that could be used to launch a torpedo and destroy the submarine. ASW Tracking Exercises occur during both day and night. A typical unit-level exercise involves one (1) ASW unit (aircraft, ship, or submarine) versus one (1) target—either a MK–39 Expendable Mobile ASW Training Target (EMATT), or a live submarine. The target may be non-evading while operating on a specified track or fully evasive. Participating units use active and passive sensors, including hull-mounted sonar, towed arrays, and sonobuoys for tracking. If the exercise continues into the firing of a practice torpedo it is termed a Torpedo Exercise (TORPEX). The ASW TORPEX usually starts as a TRACKEX to achieve the firing solution. No torpedoes are fired during ASW training conducted in the NWTRC. The exercise types that utilize MFAS/HFAS are described below and summarized in Table 2, which also includes a summary of the exercise types utilizing explosives.

ASW TRACKEX (Maritime Patrol Aircraft)—During an ASW TRACKEX (MPA), a typical scenario would involve a single MPA dropping sonobuoys, from an altitude below 3,000 ft (914 m) above mean sea level (MSL), and sometimes as low as 400 ft (122 m), into specific patterns designed for both the anticipated threat submarine and the specific water conditions. These patterns vary in size and coverage area based on the threat and water conditions.

Typically, passive sonobuoys will be used first, so the threat submarine is not alerted. Active buoys will be used as required either to locate extremely quiet submarines, or to further localize and track submarines previously detected by passive buoys. A TRACKEX (MPA) usually takes two to four hours. The P–8 Multi-mission Maritime Aircraft (MMA), a modified Boeing 737 that is the Navy's replacement for the aging P–3 Orion aircraft, is a long-range aircraft that is capable of broad-area, maritime and littoral activities. As P–8 live training is expected to be supplemented with virtual training to a greater degree than P–3 training, P–8 training activities in the NWTRC are likely to be less numerous than those currently conducted by P–3 aircraft crews. P–3 replacement is expected to begin by 2013. None of the potential marine mammal impacts associated with the P–3 aircraft are expected to differ as a result of the P–3 being replaced by the MMA.

ASW TRACKEX (EER/IEER or AEER)—This activity is an at-sea flying event, typically conducted below 3,000 ft (914 m) MSL, that is designed to train P–3 crews in the deployment and use of the EER/IEER (and in the future, AEER) sonobuoy systems. These systems use the SSQ–110A as the signal source and the SSQ–77 (VLAD) as the receiver buoy. The signal source is a small explosive charge that detonates underwater. The SSQ–110A sonobuoy has two charges, each being individually detonated during the exercise. This activity typically lasts six hours, with one hour for buoy pattern deployment and five hours for active search. Between 12 and 20 SSQ–110A source sonobuoys and approximately 20 SSQ–77 passive sonobuoys are used in a typical exercise.

ASW TRACKEX (Surface Ship)—In the PACNW OPAREA, locally based surface ships do not routinely conduct ASW Tracking exercises. However, MFAS is used during ship transits through the OPAREA. In a typical year, 24 DDG ship transits and 36 FFG transits will take place, with 1.5 hours of active sonar use during each transit. All surface ship MFAS use is documented in this training activity description. 10% of surface ship MFAS used in NWTRC is training associated with the PUTR.

ASW TRACKEX (Submarine)—ASW TRACKEX is a primary training exercise for locally based submarines. Training is conducted within the NWTRC and involves aircraft approximately 30% of the time. Training events in which aircraft are used typically last 8 to 12 hours. During these activities submarines use passive sonar sensors to search, detect, classify, localize and track the threat submarine with the goal of developing a firing solution that could be used to launch a torpedo and destroy the threat submarine. However, no torpedoes are fired during this training activity. All submarine ASW TRACKEX conducted in the NWTRC is passive only; therefore, these activities are not carried forward for any further analysis of effects. All aircraft ASW is analyzed under ASW TRACKEX (MPA).

Mine Avoidance—Mine avoidance exercises train ship and submarine crews to detect and avoid underwater mines. In the NWTRC, submarine crews will use the AN/BQS–15 high frequency active sonar to locate mine shapes in a training minefield in the PACNW OPAREA. A small-scale underwater minefield will be added in the NWTRC for these exercises. Each mine avoidance exercise involves one submarine operating the AN/BQS–15 sonar for six hours to navigate through

the training minefield. A total of seven mine avoidance exercises will occur in the NWTRC annually.

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Exercise Type	ASW TRACKEX	Mine Avoidance	EER/IEER	MISSILEX (Air based)	GUNEX	BOMBEX	SINKEX	MIW
Anticipated Takes	Yes	Yes	Yes	No *	No *	Yes	Yes	No *
Explosion in or on water	No	No	Yes	No	No	Yes	Yes	Yes
Length of Exercise	1.5 hours	6 hours	6 hours	2-3 hours	2-3 hours	1 hour	8-48 hours	5 hours
Sonar hours, sonobuoys, torpedoes, detonations, or rounds per year	SQS-53 (Search Mode) = 39 hrs/year SQS-56 = 58.5 hrs/year SSQ-62 DICASS = 886 sonobuoys/year MK-48 Torpedo = 2 torpedoes/yr	AN/BQS-15 Sonar = 42.hrs/year	SSQ-110A or AN/SSQ-125 = 149 sonobuoys/year	13 AIM-7missiles 9 AIM-9 missiles 7 AIM-120 missiles 8 NATO Sea Sparrow or 8 Rolling Airframe Missiles	5 in gun (2,463 rounds) 20 mm (16,000 rounds) 25 mm (31,500 rounds) 57 mm (1,260 rounds) 76 mm (720 rounds) .50 caliber (117,000 rounds)	10 MK-82 Bombs (High Explosive) 110 BDU-45 Bombs (Inert)	See Narrative SINKEX section	2.5.-lb NEW - 4/year
Number Exercises per Year	65	7	12	28	340	30	2	4
Area Used	Pacific Northwest Surface/ Subsurface OPAREA	Pacific Northwest Surface/ Subsurface OPAREA	Pacific Northwest Surface/ Subsurface OPAREA	Pacific Northwest Surface/ Subsurface OPAREA	Pacific Northwest Surface/ Subsurface OPAREA	Pacific Northwest Surface/ Subsurface OPAREA	Pacific Northwest Surface/ Subsurface OPAREA	EOD Crescent Harbor, EOD Indian Island, EOD Floral Point
Months of Year conducted	Year Round	Year Round	Year Round	Year Round	Year Round	Year Round	Year Round	Year Round

Table 2. Summary of exercise types in NWTRC noting duration, location, sources and explosives used, and time of year

* Though take is not anticipated to result from these exercises, they are included for information because they have been addressed in other rules

Activities Utilizing Underwater Detonations

Underwater detonation activities can occur at various depths depending on the activity, but may also include activities which may have detonations at or just below the surface (such as SINKEX or gunnery exercise [GUNEX]). When the weapons hit the target, except for live torpedo shots, there is no explosion in the water, and so a ''hit'' is not modeled (*i.e.*, the energy (either acoustic or pressure) from the hit is not expected to reach levels that would result in take of marine mammals). When a live weapon misses, it is modeled as exploding below the water surface at 1 ft (5-inch naval gunfire, 76mm rounds), 2 meters (Maverick, Harpoon, MK–82, MK–83, MK–84), or 50-ft (MK–48 torpedo) as shown in Appendix A of the Navy's application (the depth is chosen to represent the worst case of the possible scenarios as related to potential marine mammal impacts). Exercises may utilize either live or inert ordnance of the types listed in Table 3. Additionally, successful hit rates are known to the Navy and are utilized in the effects modeling. Training events that involve explosives and underwater detonations occur throughout the year and are described below and summarized in Table 2. Of note, the only Inshore Area exercises that use explosives are on EOD ranges described under Mine Countermeasures (No more than 4 total detonations of 2.5 lb. charges annually).

	NEW	TTS		Injury		Mortality	Exclusion
	lbs	182 SEL	23 psi	205 SEL	13 psi-ms	31 psi-ms	Zone Used (m)
5" Naval gunfire	9.5	247	273	46	44	24	548
76mm rounds	1.6	102	151	21	25	13	548
Demolition	2.5	179	175	35	74	31	548
Maverick	78.5	959	554	182	191	107	1852 (SINKEX), 1645 (MISSILEX)
HARM	41.6	689	448	133	156	86	1853 (SINKEX), 1645 (MISSILEX)
Hellfire	16.4	424	327	84	112	59	1854 (SINKEX), 1645 (MISSILEX)
SLAM	164.3	1406	726	262	237	137	1855 (SINKEX), 1645 (MISSILEX)
Harpoon	448	1811	866	120	270	158	1852 (SINKEX), 1645 (MISSILEX)
MK-82	238	1723	835	315	263	153	1852 (SINKEX), 914 (BOMBEX)
MK-48	851	3469	1278	662	694	424	1852 (SINKEX), 914 (BOMBEX)
GBU-10	945	3626	1326	613	373	223	1853 (SINKEX), 914 (BOMBEX)
GBU-12	238	1712	832	315	262	153	1854 (SINKEX), 914 (BOMBEX)
GBU-16	445	2390	1054	428	310	183	1855 (SINKEX), 914 (BOMBEX)
AN/SSQ-110A (IEER)	5	325	281	72	159	77	914

Table 3. Representative ordnance used in NWTRC Explosive Exercises for which take of marine mammals is anticipated.
Table also indicates range to indicated threshold and size of Navy exclusion zone used in mitigation. Units are meters.

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Anti-Surface Warfare Training (ASUW)

Anti-Surface Warfare (ASUW) is the category of activity that addresses combat (or interdiction) activities training by air, surface, or submarine forces against hostile surface ships and boats. The ASUW exercises conducted in NWTRC are described in the sections below. Because all of the rounds used in GUNEX in the NWTRC are inert, no take of marine mammals is anticipated to

result from the activity. However, a description is included here for comparison and clarity as NMFS has authorized take of marine mammals incidental to these activities in the past when explosive rounds were used instead of inert rounds.

Air-to-Surface Bombing Exercise—During an Air-to-Surface Bombing Exercise (BOMBEX A–S), fixed-wing aircraft deliver bombs against simulated surface maritime targets, typically a smoke float, with the goal of destroying or disabling enemy ships or boats. MPA use bombs to attack surfaced submarines and surface craft that would not present a major threat to the MPA itself. A single MPA approaches the target at a low altitude. In most training exercises, the aircrew drops inert training ordnance, such as the Bomb Dummy Unit (BDU–45) on a MK–58 smoke float used as the target. Historically, ordnance has been released throughout W–237 (off WA State), just south of W–237, and in international waters in accordance with international laws, rules, and regulations. Annually, 120 pieces of ordnance, consisting of 10 MK–82 live bombs and 110 BDU 45 inert bombs, are dropped in the NWTRC. In accordance with the regulations for the Olympic Coast National Marine Sanctuary (OCNMS) the Navy dos not conduct live bombing in the sanctuary. Each BOMBEX A–S can take up to 4 hours to complete.

Sinking Exercise—A Sinking Exercise (SINKEX) is typically conducted by aircraft, surface ships, and submarines in order to take advantage of a full size ship target and an opportunity to fire live weapons. The target is typically a decommissioned combatant or merchant ship that has been made environmentally safe for sinking. In accordance with EPA permits, it is towed out to sea (at least 50 nm [92.6 km]) and set adrift at the SINKEX location in deep water (at least 1,000 fathoms [6,000 feet]) where it will not be a navigation hazard to other shipping. The Environmental Protection Agency (EPA) granted the Department of the Navy a general permit through the Marine Protection, Research, and Sanctuaries Act to transport vessels ''for the purpose of sinking such vessels in ocean waters * * *'' (40 CFR Part 229.2). Subparagraph (a)(3) of this regulation states ''All such vessel sinkings shall be conducted in water at least 1,000 fathoms (6,000 feet) deep and at least 50 nautical miles from land.''

Ship, aircraft, and submarine crews typically are scheduled to attack the target with coordinated tactics and deliver live ordnance to sink the target. Inert ordnance is often used during the first stages of the event so that the target may be available for a longer time. The duration of a SINKEX is unpredictable because it ends when the target sinks, but the goal is to give all forces involved in the exercise an opportunity to deliver their live ordnance. Sometimes the target will begin to sink immediately after the first weapon impact and sometimes only after multiple impacts by a variety of weapons. Typically, the exercise lasts 4 to 8 hours, especially if inert ordnance such as 5-inch gun projectiles or MK–76 dummy bombs are used during the first hours. In the worst case of maximum exposure, the following ordnance are all expended (in the indicated amounts): MK82 Live Bomb (4); MK83 Live Bomb (4); MK84 Live Bomb (4); HARM Missile (2); AGM–114 Hellfire Missile (1); M–65 Maverick Missile (3); M–84 Harpoon Missile (3); AM ER Missile (1); 5 in/62 Shell (500); 76 mm Shell (200); 48 ADCAP Torpedo (1). If the hulk is not sunk by weapons, it will be sunk by Explosive Ordnance Disposal (EOD) personnel setting off demolition charges previously placed on the ship. Since the target may sink at any time during the exercise, the actual number of weapons used can vary widely.

Surface-to-Surface Gunnery Exercise—Surface-to-Surface Gunnery Exercises (S–S GUNEX) take place in the open ocean to provide gunnery practice for Navy ship crews. Exercises can involve a variety of surface targets that are either stationary or maneuverable. Gun systems employed against surface targets include the 5″, 76 mm, 57 mm, .50 caliber and the 7.62 mm. A GUNEX lasts approximately one to two hours, depending on target services and weather conditions. All rounds fired are inert, containing no explosives.

Mine Warfare Training (MIW)

Mine Warfare Training includes Mine Countermeasures and Mine Avoidance. Mine Avoidance includes use of an active sonar source (although in very small amounts) and, therefore, was addressed in the appropriate section previously. Because of the location of the EOD ranges, the very limited use of explosives (4 individual explosions) proposed annually for these Mine Countermeasure exercises, and the likely effectiveness of the mitigation (*e.g.*, marine mammal take is only expected within 180 m of the impact area, which is well within the shutdown zone of 700 yds from the point of impact), take of marine mammals is not anticipated to occur in the NWTRC. However, a description is included here for comparison as NMFS has authorized take of marine mammals incidental to these activities in other areas where the amount of activity is significantly greater.

Mine Countermeasures—Naval EOD personnel require proficiency in underwater mine neutralization. Mine neutralization activities consist of underwater demolitions designed to train personnel in the destruction of mines, unexploded ordnance (UXO), obstacles, or other structures in an area to prevent interference with friendly or neutral forces and non-combatants. EOD units conduct underwater demolition training in Crescent Harbor Underwater EOD Range, Indian Island Underwater EOD Range, and Floral Point Underwater EOD Range. A 2.5 lb (1.1 kg) charge of C–4 is used, consisting of one surface or one subsurface detonation. No more than two detonations will take place annually at Crescent Harbor, and no more than one each at Indian Island and Floral Point. The total duration of the exercise is four hours for an underwater detonation and one hour for a surface detonation. Small boats such as the MK–5 Combat Rubber Raiding Craft and MK–7, or 9 (meters in length, respectively) Rigid Hull Inflatable Boats (RHIB) are used to insert personnel for underwater activities and either a helicopter (H–60) or RHIB is used for insertion for surface activities.

Vessel Movement

The operation and movement of vessels that is necessary to conduct the training described above is also analyzed here. Training exercises involving vessel movements occur intermittently and are variable in duration, ranging from a few hours up to 2 weeks. During training, speeds vary and depend on the specific type of activity, although 10–14 knots is considered the typical speed. Approximately 490 training activities that involve Navy vessels occur within the Study Area during a typical year. Training activities are widely dispersed throughout the large OPAREA, which encompasses 122,468 nm^2 (420,054 km^2). Consequently, the density of Navy ships within the Study Area at any given time is low.

Research, Development, Testing, and Evaluation

RDT&E proposed in this action is limited to Unmanned Aerial Systems (UAS) activities, the use of which is not anticipated to result in the take of marine mammals because it utilizes small, relatively quiet airborne, not undersea, gliders. Undersea RDT&E in the Pacific Northwest is conducted at

the Naval Sea Systems Command (NAVSEA) Keyport range and is analyzed in the NAVSEA Naval Undersea Warfare Center (NUWC) Keyport Range Extension EIS/OEIS.

Additional information on the Navy's proposed activities may be found in the LOA Application and the Navy's NWTRC DEIS.

Description of Marine Mammals in the Area of the Specified Activities

The California Current passes through the NWTRC, creating a mixing of temperate and tropical waters, thereby making this area one of the most productive ocean systems in the world (Department of the Navy [DoN], 2002a). Because of this productive environment, there is a rich marine mammal fauna, as evidenced in abundance and species diversity (Leatherwood *et al.*, 1988; Bonnell and Dailey, 1993). In addition to many marine mammal species that live here year-round and use the region's coasts and islands for breeding and hauling out, there is a community of seasonal residents and migrants. The narrow continental shelf along the Pacific coast and the presence of the cold California Current sweeping down from Alaska allows cold-water marine mammal species to reach nearshore waters as far south as Baja California.

Thirty-three marine mammal species or populations/stocks have confirmed or possible occurrence within the NWTRC, including six species of baleen whales (mysticetes), 21 species of toothed whales (odontocetes), five species of seals and sea lions (pinnipeds), and the sea otter (mustelids). Table 4 summarizes their abundance, Endangered Species Act (ESA) status, population trends, and occurrence in the area. Most of these species are listed as ''common'' in the table, indicating that they occur routinely, either year-round or during annual migrations into or through the area. The other species are indicated as ''rare'' because of sporadic sightings or as ''very rare'' because they have been documented once or twice as appearing outside their normal range. All of the species that occur in the NWTRC are either cosmopolitan (occur worldwide), or associated with the temperate and sub-Arctic oceans (Leatherwood *et al.*, 1988). Seven of the species are ESA-listed and considered depleted under the MMPA: Blue whale; fin whale; humpback whale; sei whale; sperm whale; southern resident killer whale; and Steller sea lion.

Temperate and warm-water toothed whales often change their distribution and abundance as oceanographic conditions vary both seasonally (Forney and Barlow, 1998) and inter-annually (Forney, 2000). Forney and Barlow (1998) noted significant north/south shifts in distribution for Dall's porpoises, common dolphins, and Pacific white-sided dolphins, and they identified significant inshore/offshore differences for northern right whale dolphins and humpback whales. Several authors have noted the impact of the El Niño events of 1982/1983 and 1997/1998 on marine mammal occurrence patterns and population dynamics in the waters off California (Wells *et al.*, 1990; Forney and Barlow, 1998; Benson *et al.*, 2002).

The distribution of some marine mammal species is based on the presence of salmon, an important prey source. Seals and sea lions congregate near areas where migrating salmon run. For example, in the San Juan Islands, harbor seals (*Phoca vitulina richardii*) congregate near a constricted channel where incoming tidal currents funnel migrating salmon (Zamon, 2001). In Oregon, harbor seals wait for chum salmon runs during the incoming tide near a constriction in Netarts Bay (Brown and Mat, 1983). During the summer, southern resident killer whales (*Orcinus orca*) congregate at locations associated with high densities of migrating salmon (Heimlich-Boran, 1986; Nichol and Shackleton, 1996; Olson, 1998; National Marine Fisheries Service [NMFS], 2005i). Their strong preference for Chinook salmon may influence the year-round distribution patterns of southern resident killer whales in the NWTRC (Ford and Ellis, 2005).

The Navy has compiled information on the abundance, behavior, status and distribution, and vocalizations of marine mammal species in the NWTRC waters from the Navy Marine Resource Assessment for NWTRC (which was recently updated, during the development of the application for this rule, based on peer-reviewed literature and government reports such as NMFS' Stock Assessment Reports) and marine mammal experts engaged in current research utilizing tagging and tracking. This information may be viewed in the Navy's LOA application and/or the Navy's DEIS for NWTRC (*see* Availability), and is incorporated by reference herein. Included below, however, are summaries of some important biological issues that are needed to further inform the MMPA effects analysis. Additional information is available in NMFS Stock Assessment Reports, which may be viewed at: *http://www.nmfs.noaa.gov/pr/sars/species.htm.*

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Common Name *Species Name*	Abundance (CV)	Stock	Calculated Density (animals per km2)	Population Trend	Occurrence	Warm Season (May-Oct)	Cold Season (Nov-Apr)
ESA Listed Baleen Whales							
Blue whale[1,2,3] *Balaenoptera musculus*	1,186 (0 19)	Eastern North Pacific	0.0005[a]	May be increasing	Common	Yes	No
Fin whale[1,2,3] *Balaenoptera physalus*	3454 (0.27)	California, Oregon, and Washington	0.0014[a]	May be increasing	Common	Yes	Yes
Humpback whale[1,2,3] *Megaptera novaeangliae*	1,396 (0.15)	Eastern North Pacific	0.0007[a]	Increasing	Common	Yes	No
Sei whale[1,2,3] *Balaenoptera borealis*	43 (0.61)	Eastern North Pacific	0.000115[c] 0.000182[d]	May be increasing	Common	Yes	No
ESA Listed Toothed Whales							
Sperm whale[1,2,3] *Physeter macrocephalus*	2,265 (0.34)	California, Oregon, and Washington, Offshore	0.0026[a]	Unknown	Common	Yes	Yes
Southern resident killer whale[1,2] *Orcinus orca*	89	Eastern North Pacific, Southern Resident	0.00055/.00162	possibly decreasing	Common	Yes	Yes
ESA Listed Pinniped							
Steller sea lion[2,4] *Eumetopias jubatus*	48,519	Eastern	0.000011 / 0.011[b]	possibly increasing	Common	Yes	Yes
Non-ESA Listed Baleen Whales							
Gray whale *Eschrichtius robustus*	18,178	Eastern North Pacific	--	Increasing	Common	No	Yes
Minke whale *Balaenoptera acutorostrata*	898 (0 65)	California, Oregon, and Washington	0.000655[c] 0.000395[d]	No trends	Common	No	Yes
Non-ESA Listed Toothed Whales							
Baird's beaked whale *Berardius bairdii*	313 (0.55)	California, Oregon, and Washington	0.001614[c] 0.000775[d]	Unknown	Common	Yes	Yes
Bottlenose dolphin offshore *Tursiops truncatus*	3,257 (0.43)	California, Oregon, Washington, Offshore	0.000515[c]	No trend	Very Rare	Yes	Yes
Cuvier's beaked whale *Ziphius cavirostris*	2,171 (0.75)	California, Oregon, and Washington	0.003038[c]	Unknown	Common	Yes	Unknown
Dall's porpoise *Phocoenoides dalli*	57,549 (0.34)	California, Oregon, and Washington	0.0970[a]	Unknown	Common	No	Yes
Dwarf sperm whale *Kogia sima*	unknown	California, Oregon, and Washington	--	Unknown	Very Rare	Unknown	Yes
Harbor porpoise *Phocoena phocoena*	17,763 (0.39)	Northern California/ Southern Oregon	--	Stable	Common	Yes	Yes
	37,745 (0.38)	Washington/ Oregon Coastal		Stable			
	10,682 (0.38)	Washington Inland Waters		Stable			
Killer whale offshore *Orcinus orca*	422	Eastern North Pacific Offshore	.00055/.00162	Unknown	Common	No	Yes
Killer whale transient *Orcinus orca*	346	Eastern North Pacific Transient	.00055/.00162	Unknown	Common	No	Yes
Mesoplodont beaked whales[e] *Mesoplodon sp.*	1,024 (0.77)	Washington, Oregon, and California	0.00135[c] 0.001321[d]	Unknown	Rare	Unknown	Unknown
Northern right whale dolphin *Lissodelphis borealis*	15,305 (0.232)	California, Oregon, and Washington	0.0014[a]	No trend	Common	Yes	Yes
Pacific white-sided dolphin *Lagenorhynchus obliguidens*	25,233 (0.25)	California, Oregon, and Washington	0.0441[a]	No trend	Common	Yes	Yes
Non-ESA Listed Toothed Whales (continued)							
Pygmy sperm whale *Kogia breviceps*	Unknown	California, Oregon, and Washington	0.001232[c] 0.000504[d]	Unknown	Common	Unknown	Unknown
Risso's Dolphin *Grampus griseus*	12,093 (0.24)	California, Oregon, and Washington	0.013222[c] 0.004014[d]	No trend	Common	Yes	Yes
Short-beaked common dolphin *Delphinus delphis*	487,622 (0.26)	California, Oregon, and Washington	0.1570[a]	Varies by oceanographic	Common	Yes	Yes
Short-finned pilot whale *Globicephala macrorhynchus*	245 (0 97)	California, Oregon, and Washington	--	Unknown	Rare	Unknown	Unknown
Striped dolphin *Stenella coeruleoalba*	23,883 (0.44)	California, Oregon, and Washington	0.0000497[c] 0.015653[d]	No trend	Rare	No	Unknown
Non-ESA Listed Pinnipeds							
California sea lion *Zalophus californianus*	238,000	U.S.	--	Increasing	Common	Yes	Yes
Harbor seal	34,233	California	--	Increasing	Common	Yes	Yes
	24,732 (0.12)	Washington/ Oregon Coastal		Stable			
	14,612 (0.15)	Washington Inland		Stable			
Northern elephant seal *Mirounga angustirostris*	124,000	California Breeding	--	Increasing	Common	Yes	Yes
Northern fur seal *Callorhinus ursinus*	721,935	Eastern Pacific	--	Increasing	Common	Yes	Yes

Table 4. Marine mammals of known occurrence in the NWTRC.

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Species Not Considered Further

The North Pacific right whale is classified as endangered under the ESA. Although there is designated critical habitat for this species in the western Gulf of Alaska and an area in the southeastern Bering Sea (NMFS, 2006), there is no designated critical habitat for this species within the NWTRC. Census data are too limited to suggest a population trend for this species. In the western North Pacific, the population may number in the low hundreds (Brownell *et al.*, 2001; Clapham *et al.*, 2004). The eastern population likely now numbers in the tens of animals. Right whales were probably never common along the west coast of North America (Scarff, 1986; Brownell *et al.*, 2001). Historical whaling records provide the most complete information on likely North Pacific right whale

distribution. Presently, sightings are extremely rare, occurring primarily in the Okhotsk Sea and the eastern Bering Sea (Brownell *et al.*, 2001; Shelden *et al.*, 2005; Shelden and Clapham, 2006; Wade *et al.*, 2006). There were no sightings of North Pacific right whales during ship surveys conducted off California, Oregon, and Washington from 1991 through 2005 (Barlow and Forney, 2007), although recent deployment of directional sonobuoys (focused on the gunshot call) in the southeastern Bering Sea has resulted in multiple recordings of the rarely detected marine mammals (Berchok *et al.*, 2009). The area of densest concentration in the Gulf of Alaska is east from 170° W to 150° W and south to 52° N (Shelden and Clapham, 2006). Based upon the extremely low probability of encountering this species anywhere in the coastal and offshore waters in the NWTRC, this species will not be included in this analysis.

Designated Critical Habitat

Southern Resident Killer Whale

NMFS designated critical habitat for the southern resident killer whale (*Orcinus orca*) distinct population segment (DPS). Three specific areas (which comprise approximately 2,560 square miles (6,630 sq km) of marine habitat) are designated:

(1) *The Summer Core Area in Haro Strait and waters around the San Juan Islands*—Occurrence of Southern Residents in Area 1 coincides with concentrations of salmon, and is more consistent and concentrated in the summer months of June through August, though they have been sighted in Area 1 during every month of the year;

(2) *Puget Sound*—southern resident killer whale occurrence in Area 2 has been correlated with fall salmon runs; and

(3) *The Strait of Juan de Fuca*—All pods regularly use the Strait of Juan de Fuca for passage from Areas 1 and 2 to outside waters in the Pacific Ocean and to access outer coastal water feeding grounds.

The designated physical and biological features which are essential to the conservation of southern resident killer whales and that may require special management considerations or protection (Primary Constituent Elements/PCEs) are as follows:

(1) *Water quality to support growth and development*—Because of their long life span, position at the top of the food chain, and their blubber stores, southern resident killer whales accumulate high concentrations of contaminants;

(2) *Prey species of sufficient quantity, quality and availability to support individual growth, reproduction and development, as well as overall population growth*—Fish are the major dietary component of southern resident killer whales in the northeastern Pacific. Salmon comprise the southern resident killer whales' preferred prey, and are likely consumed in large amounts; and

(3) *Passage conditions to allow for migration, resting, and foraging*—In order to move between important habitat areas, find prey, and fulfill other life history requirements, southern resident killer whales require open waterways that are free from obstruction.

As noted previously, the Navy's proposed action does not include the use of MFAS/HFAS in southern resident killer whale critical habitat, and explosive use is limited to four detonations of 2.5-lb charges annually in EOD exercises.

Steller Sea Lion

In California and Oregon, major Steller sea lion rookeries and associated air and aquatic zones are designated as critical habitat. Critical habitat includes an air zone extending 3,000 ft above rookery areas historically occupied by sea lions and an aquatic zone extending 3,000 seaward. Three rookeries located along the southern Oregon Coast have been designated as critical habitat sites in the NWTRC. These include: Orford Reef (Long Brown Rock); Oxrord Reef (Seal Rock); Rogue Reef (Pyramid Rock). The PCEs for Steller sea lions are: Nearshore waters around rookeries and haulouts and prey resources and foraging habitats.

Gray Whale Migration

The gray whale makes a well-defined seasonal north-south migration. Most of the population summers in the shallow waters of the northern Bering Sea, the Chukchi Sea, and the western Beaufort Sea (Rice and Wolman, 1971), whereas some individuals also summer along the Pacific coast from Vancouver Island to central California (Rice and Wolman, 1971; Darling 1984; Nerini, 1984). In October and November, the whales begin to migrate southeast through Unimak Pass and follow the shoreline south to breeding grounds on the west coast of Baja California and the southeastern Gulf of California (Braham, 1984; Rugh, 1984). The average gray whale migrates 7,500–10,000 km at a rate of 147 km/d (Rugh *et al.*, 2001; Jones and Swartz, 2002). Although some calves are born along the coast of California, most are born in the shallow, protected waters on the Pacific coast of Baja California from Morro de Santo Domingo (28° N) south to Isla Creciente (24° N) (Urban *et al.*, 2003). The main calving sites are Laguna Guerrero Negro, Laguna Ojo de Liebre, Laguna San Ignacio, and Estero Soledad (Rice *et al.*, 1981).

Gray whales occur in the Pacific Northwest OPAREA and Puget Sound throughout the year. In addition, larger numbers of migratory animals transit along the coast of Washington, Oregon, and California during migrations between breeding and feeding grounds. Peak sightings in the NWTRC during the southbound migration occur in January (Rugh *et al.*, 2001). There are two phases of the northbound migration, including an early phase from mid-February through April and a later phase, which consists of mostly cows and calves, from late April through May (Herzing and Mate, 1984).

Marine Mammal Hearing and Vocalizations

Cetaceans have an auditory anatomy that follows the basic mammalian pattern, with some changes to adapt to the demands of hearing in the sea. The typical mammalian ear is divided into an outer ear, middle ear, and inner ear. The outer ear is separated from the inner ear by a tympanic membrane, or eardrum. In terrestrial mammals, the outer ear, eardrum, and middle ear transmit airborne sound to the inner ear, where the sound waves are propagated through the cochlear fluid. Since the impedance of water is close to that of the tissues of a cetacean, the outer ear is not required to transduce sound energy as it does when sound waves travel from air to fluid (inner ear). Sound waves traveling through the inner ear cause the basilar membrane to vibrate. Specialized cells, called hair cells, respond to the vibration and produce nerve pulses that are transmitted to the central nervous system. Acoustic energy causes the basilar membrane in the cochlea to vibrate. Sensory cells at different positions along the basilar membrane are excited by different frequencies of sound (Pickles, 1998). Baleen whales have inner ears that appear to be specialized for low-frequency hearing. Conversely, dolphins and porpoises have ears that are specialized to hear high frequencies.

Marine mammal vocalizations often extend both above and below the range of human hearing; vocalizations with frequencies lower than 18 Hertz (Hz) are labeled as infrasonic and those higher than 20 kHz as ultrasonic (National Research Council [NRC], 2003; Figure 4–1). Measured data on the hearing

abilities of cetaceans are sparse, particularly for the larger cetaceans such as the baleen whales. The auditory thresholds of some of the smaller odontocetes have been determined in captivity. It is generally believed that cetaceans should at least be sensitive to the frequencies of their own vocalizations. Comparisons of the anatomy of cetacean inner ears and models of the structural properties and the response to vibrations of the ear's components in different species provide an indication of likely sensitivity to various sound frequencies. The ears of small toothed whales are optimized for receiving high-frequency sound, while baleen whale inner ears are best in low to infrasonic frequencies (Ketten, 1992; 1997; 1998).

Baleen whale vocalizations are composed primarily of frequencies below 1 kHz, and some contain fundamental frequencies as low as 16 Hz (Watkins *et al.*, 1987; Richardson *et al.*, 1995; Rivers, 1997; Moore *et al.*, 1998; Stafford *et al.*, 1999; Wartzok and Ketten, 1999) but can be as high as 24 kHz (humpback whale; Au *et al.*, 2006). Clark and Ellison (2004) suggested that baleen whales use low frequency sounds not only for long-range communication, but also as a simple form of echo ranging, using echoes to navigate and orient relative to physical features of the ocean. Information on auditory function in mysticetes is extremely lacking. Sensitivity to low-frequency sound by baleen whales has been inferred from observed vocalization frequencies, observed reactions to playback of sounds, and anatomical analyses of the auditory system. Although there is apparently much variation, the source levels of most baleen whale vocalizations lie in the range of 150–190 dB re 1 µPa at 1 m. Low-frequency vocalizations made by baleen whales and their corresponding auditory anatomy suggest that they have good low-frequency hearing (Ketten, 2000), although specific data on sensitivity, frequency or intensity discrimination, or localization abilities are lacking. Marine mammals, like all mammals, have typical U-shaped audiograms that begin with relatively low sensitivity (high threshold) at some specified low frequency with increased sensitivity (low threshold) to a species specific optimum followed by a generally steep rise at higher frequencies (high threshold) (Fay, 1988).

The toothed whales produce a wide variety of sounds, which include species-specific broadband ''clicks'' with peak energy between 10 and 200 kHz, individually variable ''burst pulse'' click trains, and constant frequency or frequency-modulated (FM) whistles ranging from 4 to 16 kHz (Wartzok and Ketten, 1999). The general consensus is that the tonal vocalizations (whistles) produced by toothed whales play an important role in maintaining contact between dispersed individuals, while broadband clicks are used during echolocation (Wartzok and Ketten, 1999). Burst pulses have also been strongly implicated in communication, with some scientists suggesting that they play an important role in agonistic encounters (McCowan and Reiss, 1995), while others have proposed that they represent ''emotive'' signals in a broader sense, possibly representing graded communication signals (Herzing, 1996). Sperm whales, however, are known to produce only clicks, which are used for both communication and echolocation (Whitehead, 2003). Most of the energy of toothed whales social vocalizations is concentrated near 10 kHz, with source levels for whistles as high as 100–180 dB re 1 µPa at 1 m (Richardson *et al.*, 1995). No odontocete has been shown audiometrically to have acute hearing (<80 dB re 1 µPa) below 500 Hz (DoN, 2001). Sperm whales produce clicks, which may be used to echolocate (Mullins *et al.*, 1988), with a frequency range from less than 100 Hz to 30 kHz and source levels up to 230 dB re 1 µPa 1 m or greater (Mohl *et al.*, 2000).

Table 5 includes a summary of the vocalizations of the species found in the NWTRC. The ''Brief Background on Sound'' section contained a description of the functional hearing groups designated by Southall *et al.,* (2007), which includes the functional hearing range of various marine mammal groups (*i.e.*, what frequencies that can actually hear).

Marine Mammal Density Estimates

Understanding the distribution and abundance of a particular marine mammal species or stock is necessary to analyze the potential impacts of an action on that species or stock. Further, in order to assess quantitatively the likely acoustic impacts of a potential action on individuals and to estimate take it is necessary to know the density of the animals in the affected area. Density estimates for cetaceans were obtained from the Marine Mammal and Sea Turtle Density Estimates for the Pacific Northwest Study Area (DoN, 2007a). The abundance of most cetaceans was derived from shipboard surveys conducted by the Southwest Fisheries Science Center in 1991, 1993, 1996, 2001, and 2005 (Barlow, 1995; Barlow, 2003; Barlow and Forney, 2007). These estimates are used to develop NMFS Stock Assessment Reports (Carretta *et al.*, 2007); interpret the impacts of human-caused mortality associated with fishery bycatch, ship strikes, and other sources; and evaluate the ecological role of cetaceans in the eastern North Pacific. In the density study, predictive species-habitat models were built for species with sufficient numbers of sightings to estimate densities for the NWTRC (described in detail Appendix B of the Navy's application). For species with insufficient numbers of sightings, density estimates were obtained from Barlow and Forney (2007).

There are limited depth distribution data for most marine mammals. This is especially true for cetaceans, as they must be tagged at-sea and by using a tag that either must be implanted in the skin/blubber in some manner or adhere to the skin. There is slightly more data for some pinnipeds, as they can be tagged while on shore during breeding or molting seasons and the tags can be glued to the pelage rather than implanted. There are a few different methodologies/techniques that can be used to determine depth distribution percentages, but by far the most widely used technique currently is the time-depth recorder. These instruments are attached to the animal for a fairly short period of time (several hours to a few days) via a suction cup or glue, and then retrieved immediately after detachment or when the animal returns to the beach. Depth information can also be collected via satellite tags, sonic tags, digital tags, and, for sperm whales, via acoustic tracking of sounds produced by the animal itself.

There are somewhat suitable depth distribution data for a few marine mammal species. Sample sizes are usually extremely small, nearly always fewer than 10 animals total and often only one or two animals. Depth distribution information often must be interpreted from other dive and/or preferred prey characteristics. Depth distributions for species for which no data are available are extrapolated from similar species.

Density is nearly always reported for an area, *e.g.*, animals/km^2. Analyses of survey results using Distance Sampling techniques include correction factors for animals at the surface but not seen as well as animals below the surface and not seen. Therefore, although the area (*e.g.*, km^2) appears to represent only the surface of the water (two-dimensional), density actually implicitly includes animals anywhere within the water column under that surface area. Density assumes that animals are uniformly distributed within the prescribed area,

even though this is likely rarely true. Marine mammals are usually clumped in areas of greater importance (and often in groups), for example, areas of high productivity, lower predation, safe calving, *etc.* Density can occasionally be calculated for smaller areas that are used regularly by marine mammals, but more often than not there are insufficient data to calculate density for small areas. Therefore, assuming an even distribution within the prescribed area remains the norm.

Assuming that marine mammals are distributed evenly within the water column is not accurate. The ever-expanding database of marine mammal behavioral and physiological parameters obtained through tagging and other technologies has demonstrated that marine mammals use the water column in various ways, with some species capable of regular deep dives (<800 m) and others regularly diving to <200 m, regardless of the bottom depth. Assuming that all species are evenly distributed from surface to bottom is almost never appropriate and can present a distorted view of marine mammal distribution in any region.

By combining marine mammal density with depth distribution information, a more accurate three-dimensional density estimate is possible. These 3–D estimates allow more accurate modeling of potential marine mammal exposures from specific noise sources. Density estimates are included in Table 4.

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Species	Signal Type	Frequency Range (kHz)	Frequency Near Max energy (kHz)	Source Level (dB re 1 μPa)	Duration / Other
Blue whale	moans, long duration songs	0.012 - .4	.012 - .025	188	up to 36 s, repeated every 1 - 2 min
	FM sweeps	0.858 ± 0.148			< 5 s
	vocalizations	0.012 - .4	.012 - .025		
Fin whale	vocalizations	- / .015 - .028	- / -	159-184 / 185-192	
	moans	0.016 - 0.75	0.02	160-190	
	pulses	0.04 - 0.075 / 0.018 - 0.025	- / 0.02		
	ragged pulse	< 0.03			
	rumbles	- / 0.01 - 0.03	< 0.03 / -		
	moans, downsweeps	0.014 - 0.118	0.02	160-186	
	constant call	0.02 - 0.04			
	moans, tones, upsweeps	0.03 - 0.75		155-165	
	whistles, chirps	1.5 - 5	1.5 - 2.5		
	clicks	16 - 28			
	vocal sequence, ♂ only	0.015 - 0.03			
	FM sweeps	0.018 - .23		184 - 186	1 s
Humpback whale	social	.020 - 10 / 0.05 -10	<3 / 0.1 - 4		
	songs	0.03 - 8 / -	0.12 - 4 / -	144 - 186 / 151-173	
	shrieks		0.75 - 1.8	179-181	
	horn blasts		0.41 - 0.42	181-185	
	moans	0.02 - 1.8	0.035 - 0.36	175	
	grunts	0.025 - 1.9		190	
	pulse trains	0.025 - 1.25	0.025 - 0.080	179-181	
	slap	0.03 - 1.2		183-192	
	feeding calls	0.02 - 2	0.5	162 -192	< 1 s
Humpback (calf)	simple vocalization	0.14 - 4	0.22 (mean)		
Sei whale	FM sweeps	1.5 - 3.5			7 to 20 sweeps lasting 4 ms
	growls, whooshes, tonal calls	0.433		156	.45 s
	growls and whooshes	0.241 - 0.625		152.4 - 159.6	
Gray whale	broadband signals	0.1 - 12			
	call	0.2 - 2.5	1 - 1.5		
	moans	0.02 - 1.2 / -	0.2 - 0.2 / 0.7 - 1.	185 / -	
	modulated pulse	0.08 - 1.8	0.225 - 0.6		
	FM sweeps	0.10 - 0.35	0.3		
	pulses	0.1 - 2	0.3 - 0.825		
Gray whale, Calf	clicks	0.1 - 20	3.4 - 4		
Minke whale	sweeps, moans	0.06 - 0.14		151-175	
	down sweeps	0.06 - 0.13		165	
	moans, grunts	0.06 - 0.14	0.06 - 0.14	151-175	
	ratchet	0.85 - 6	0.85		
	thump trains	0.1 - 2	0.1 - 0.2		
	speed up pulse train	0.2 - 0.4			40 to 60 ms
	slow down pulse train	0.25 - 0.35			70 to 140 ms
	Star Wars vocalization	0.05 - 9.4		150-165	
	Breeding Boings (pulse then amp-mod. call)	1.3 - 1.4			2.5 s with slight frequency modulation
	vocalizations	0.06 - 12			

Table 5a. Summary of mysticete vocalization information compiled from The Biology of Marine Mammals (Reynolds and Rommel (eds), 1999) and the Navy's SOCAL, AFAST, HRC, and NWTRC EISs - see those documents for specific information.

Species	Signal Type	Frequency Range (kHz)	Frequency Near Max energy	Source Level (dB re 1 µPa)	Duration / Other
Sperm whale	clicks	0.1 - 30	2 - 4, 10 - 16	160 - 180	< 30 ms
	short clicks			236	< 1 µs, highly directional
	trumpets			172	
Sperm (Neonate)	clicks		0.5	140 - 162	< 2 to 12 ms, low directionality
S. Resident	whistles	1.5 - 18	6 - 12		
Killer Whale	clicks	0.1 - 35 / 0.25 - 0.5	12 - 25	180	
	scream	2			
	pulsed calls	0.5 - 25	1 - 6	160	
	echolocation clicks		45 - 80	195 - 224	< 80 - 120 µs
	echolocation clicks		22 - 49	173 - 202	< 31 - 203 µs
Bottlenose	whistles	0.8 - 24	3.5 - 14.5	125-173	
dolphin	whistle	4 - 20			
	click	0.2 - 150	30 - 60		
	click		110 - 130	218 - 228	
	clicks and burst-pulses	110 - 130		218 - 228	
	bark	0.2 - 16			
Northern right	clicks high repetition		170		
whale dolphin	echolocation clicks	23 - 41			
	whistles, tones	16-Jan	1.8, 3		
Pacific white-	whistles	.002 - .02	12-Apr		
sided dolphin	pulse trains for echolocation	- / -	50 - 80 / 60 -80	170 / 180	
Risso's dolphin	whistles		3.5 - 4.5		
dolphin	rasp / pulse burst	0.1 - > 8	2 - 5		
	click		65	~120	
	whistle / burst	4 - 22			< 1 sec to several s
	broadband clicks	6 - > 22			
	narrowband grunts	0.4 - 0.8			
	echolocation clicks	30 - 50, 80 - 100		up to 216	
	echolocation clicks		50 -65	up to 222	< 40 - 70 µs
Common dolphin	whistles, chirps		0.5 - 18		
	whistles	4 - 16			
	click	0.2 - 150	30 - 60	170	
	clicks		23 - 67		
	chips and barks	0.5 - 14			
	whistles	2 - 18		180	
Striped dolphin	whistles	1 - 22.5	6.8 - 16.9	109-125	
	whistles	6 - 24	8 - 12.5		
	pulse bursts	wideband	5 - 60	108-115	
Dall's porpoise	clicks		120 - 160	120 - 148 /	50 to 1,500 µsec
	clicks	0.04 - 12 / -	- / 135 - 149	165-175	
Harbor Porpoise	clicks	2		100	
	click		110-150	135-177	
	pulse	100-160	110-150		
Short-finned	whistles	0.5 - > 20	2 to 14	180	
pilot whale	click		30 - 60	180	
Dwarf sperm w.	clicks	13-33			0.3 - 0.5 s
Pygmy sperm	clicks	60 - 200	120		
whale	narrowband pulses		129	175	119 µs, interclk intervals 40-70 ms
	echolocation clicks	60 - 200	120 - 130		
Baird's beaked	echolocation	.3 - 129			
whale	social	0.002 - 0.016			
Cuvier's beaked	echolocation clicks	20 - 40, 20 - 70		214	< 200 to 250 µs, depths > 200 m
whale	whistles	8 - 12			upsweep lasts 1 s
	pulses	13 - 17			15 to 44 s
N. elephant seal					
Pacific harbor seal	communication	.100 - 1			
	clicks	8 - 150	12 - 40		
	roar	0.4 - 4	0.4 - 0.8		
	growl, grunt, groan	< 0.1 - 0.4	< 0.1 - 0.25		
	creak	0.7 - 4	0.7 - 2		
California sea lion	barks	< 8	< 3.5		
	whinny	< 1 - 3			
	clicks		0.5 - 4		
	buzzing	< 1 - 4	< 1		
Northern fur seal	clicks, bleats				
Steller Sea Lion					

Table 5b. Summary of odontocete and pinniped vocalization information compiled from The Biology of Marine Mammals (Reynolds and Rommel (eds), 1999) and the Navy's SOCAL, AFAST, HRC, and NWTRC EISs - see those documents for specific information.

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Brief Background on Sound

An understanding of the basic properties of underwater sound is necessary to comprehend many of the concepts and analyses presented in this document. A summary is included below.

Sound is a wave of pressure variations propagating through a medium (for the MFAS/HFAS considered in this proposed rule, the medium is marine water). Pressure variations are created by compressing and relaxing the medium. Sound measurements can be expressed in two forms: Intensity and pressure. Acoustic intensity is the average rate of energy transmitted through a unit area in a specified direction and is expressed in watts per square meter (W/m^2). Acoustic intensity is rarely measured directly, it is derived from ratios of pressures; the standard reference pressure for underwater sound is 1 microPascal (μPa); for airborne sound, the standard reference pressure is 20 μPa (Richardson *et al.*, 1995).

Acousticians have adopted a logarithmic scale for sound intensities, which is denoted in decibels (dB). Decibel measurements represent the ratio between a measured pressure value and a reference pressure value (in this case 1 μPa or, for airborne sound, 20 μPa). The logarithmic nature of the scale means that each 10 dB increase is a ten-fold increase in power (*e.g.*, 20 dB is a 100-fold increase, 30 dB is a 1,000-fold increase). Humans perceive a 10-dB increase in noise as a doubling of loudness, or a 10 dB decrease in noise as a halving of loudness. The term ''sound pressure level'' implies a decibel measure and a reference pressure that is used as the denominator of the ratio. Throughout this document, NMFS uses 1 microPascal (denoted re: μPa) as a standard reference pressure unless noted otherwise.

It is important to note that decibels underwater and decibels in air are not the same and cannot be directly compared. To estimate a comparison between sound in air and underwater, because of the different densities of air and water and the different decibel standards (*i.e.*, reference pressures) in water and air, a sound with the same intensity (*i.e.*, power) in air and in water would be approximately 63 dB quieter in air. Thus a sound that is 160 dB loud underwater would have the same approximate effective intensity as a sound that is 97 dB loud in air.

Sound frequency is measured in cycles per second, or Hertz (abbreviated Hz), and is analogous to musical pitch; high-pitched sounds contain high frequencies and low-pitched sounds contain low frequencies. Natural sounds in the ocean span a huge range of frequencies: From earthquake noise at 5 Hz to harbor porpoise clicks at 150,000 Hz (150 kHz). These sounds are so low or so high in pitch that humans cannot even hear them; acousticians call these infrasonic (typically below 20 Hz) and ultrasonic (typically above 20,000 Hz) sounds, respectively. A single sound may be made up of many different frequencies together. Sounds made up of only a small range of frequencies are called ''narrowband'', and sounds with a broad range of frequencies are called ''broadband''; explosives are an example of a broadband sound source and active tactical sonars are an example of a narrowband sound source.

When considering the influence of various kinds of sound on the marine environment, it is necessary to understand that different kinds of marine life are sensitive to different frequencies of sound. Based on available behavioral data, audiograms derived using auditory evoked potential (AEP) techniques, anatomical modeling, and other data, Southall *et al.*, (2007) designate ''functional hearing groups'' for marine mammals and estimate the lower and upper frequencies of functional hearing of the groups. Further, the frequency range in which each group's hearing is estimated as being most sensitive is represented in the flat part of the M-weighting functions developed for each group. The functional groups and the associated frequencies are indicated below (though, again, animals are less sensitive to sounds at the outer edge of their functional range and most sensitive to sounds of frequencies within a smaller range somewhere in the middle of their functional hearing range):

- Low frequency cetaceans (13 species of mysticetes): Functional hearing is estimated to occur between approximately 7 Hz and 22 kHz;
- Mid-frequency cetaceans (32 species of dolphins, six species of larger toothed whales, and 19 species of beaked and bottlenose whales): Functional hearing is estimated to occur between approximately 150 Hz and 160 kHz;
- High frequency cetaceans (eight species of true porpoises, six species of river dolphins, Kogia, the franciscana, and four species of cephalorhynchids): Functional hearing is estimated to occur between approximately 200 Hz and 180 kHz;
- *Pinnipeds in Water:* Functional hearing is estimated to occur between approximately 75 Hz and 75 kHz, with the greatest sensitivity between approximately 700 Hz and 20 kHz.

Because ears adapted to function underwater are physiologically different from human ears, comparisons using decibel measurements in air would still not be adequate to describe the effects of a sound on a whale. When sound travels away from its source, its loudness decreases as the distance traveled (propagates) by the sound increases. Thus, the loudness of a sound at its source is higher than the loudness of that same sound a kilometer distant. Acousticians often refer to the loudness of a sound at its source (typically measured one meter from the source) as the source level and the loudness of sound elsewhere as the received level. For example, a humpback whale three kilometers from an airgun that has a source level of 230 dB may only be exposed to sound that is 160 dB loud, depending on how the sound propagates (in this example, it is spherical spreading). As a result, it is important not to confuse source levels and received levels when discussing the loudness of sound in the ocean or its impacts on the marine environment.

As sound travels from a source, its propagation in water is influenced by various physical characteristics, including water temperature, depth, salinity, and surface and bottom properties that cause refraction, reflection, absorption, and scattering of sound waves. Oceans are not homogeneous and the contribution of each of these individual factors is extremely complex and interrelated. The physical characteristics that determine the sound's speed through the water will change with depth, season, geographic location, and with time of day (as a result, in actual MFAS/HFAS operations, crews will measure oceanic conditions, such as sea water temperature and depth, to calibrate models that determine the path the sonar signal will take as it travels through the ocean and how strong the sound signal will be at a given range along a particular transmission path). As sound travels through the ocean, the intensity associated with the wavefront diminishes, or attenuates. This decrease in intensity is referred to as propagation loss, also commonly called transmission loss.

Metrics Used in This Document

This section includes a brief explanation of the two sound measurements (sound pressure level (SPL) and sound exposure level (SEL)) frequently used in the discussions of acoustic effects in this document.

SPL

Sound pressure is the sound force per unit area, and is usually measured in micropascals (μPa), where 1 Pa is the pressure resulting from a force of one newton exerted over an area of one square meter. SPL is expressed as the ratio of a measured sound pressure and a reference level. The commonly used reference pressure level in underwater acoustics is 1 μPa, and the units for SPLs are dB re: 1 μPa.

SPL (in dB) = 20 log (pressure / reference pressure)

SPL is an instantaneous measurement and can be expressed as the peak, the peak-peak, or the root mean square (rms). Root mean square, which is the square root of the arithmetic average of the squared instantaneous pressure values, is typically used in discussions of the effects of sounds on vertebrates and all references to SPL in this document refer to the root mean square. SPL does not take the duration of a sound into account. SPL is the applicable metric used in the risk continuum, which is used to estimate behavioral harassment takes (*see* Level B Harassment Risk Function (Behavioral Harassment) Section).

SEL

SEL is an energy metric that integrates the squared instantaneous sound pressure over a stated time interval. The units for SEL are dB re: 1 $\mu Pa^2 - s$.

SEL = SPL + 10log (duration in seconds)

As applied to MFAS/HFAS, the SEL includes both the SPL of a sonar ping and the total duration. Longer duration pings and/or pings with higher SPLs will have a higher SEL. If an animal is exposed to multiple pings, the SEL in each individual ping is summed to calculate the total SEL. The total SEL depends on the SPL, duration, and number of pings received. The thresholds that NMFS uses to indicate at what received level the onset of temporary threshold shift (TTS) and permanent threshold shift (PTS) in hearing are likely to occur are expressed in SEL.

Potential Effects of Specified Activities on Marine Mammals

The Navy has requested authorization for the take of marine mammals that may occur incidental to training activities in the NWTRC utilizing MFAS/HFAS or underwater detonations. In addition to MFAS/HFAS and underwater detonations, the Navy has analyzed other potential impacts to marine mammals from training activities in the NWTRC DEIS, including ship strike, aerial overflights, ship noise and movement, and others, and, in consultation with NMFS as a cooperating agency for the NWTRC DEIS, has determined that take of marine mammals incidental to these non-acoustic components of the NWTRC is unlikely and, therefore, has not requested authorization for take of marine mammals that might occur incidental to these non-acoustic components. In this document, NMFS analyzes the potential effects on marine mammals from exposure to MFAS/HFAS and underwater detonations, but also includes some additional analysis of the potential impacts from vessel operation in the NWTRC.

For the purpose of MMPA authorizations, NMFS' effects assessments serve four primary purposes: (1) To help identify the permissible methods of taking, meaning: the nature of the take (*e.g.*, resulting from anthropogenic noise vs. from ship strike, etc.); the regulatory level of take (*i.e.*, mortality vs. Level A or Level B harassment), and; the amount of take; (2) to inform the prescription of means of affecting the least practicable adverse impact on such species or stock and its habitat (*i.e.*, mitigation); (3) to support the determination of whether the specified activity will have a negligible impact on the affected species or stocks of marine mammals (based on the likelihood that the activity will adversely affect the species or stock through effects on annual rates of recruitment or survival); and (4) to determine whether the specified activity will have an unmitigable adverse impact on the availability of the species or stock(s) for subsistence uses (however, there are no subsistence communities that would be affected in the NWTRC).

More specifically, for activities involving sonar or underwater detonations, NMFS' analysis will identify the probability of lethal responses, physical trauma, sensory impairment (permanent and temporary threshold shifts and acoustic masking), physiological responses (particular stress responses), behavioral disturbance (that rises to the level of harassment), and social responses that would be classified as behavioral harassment or injury and/or would be likely to adversely affect the species or stock through effects on annual rates of recruitment or survival. In this section, we will focus qualitatively on the different ways that MFAS/HFAS and underwater explosive detonations may affect marine mammals (some of which NMFS would not classify as harassment). Then, in the Estimated Take of Marine Mammals Section, NMFS will relate the potential effects to marine mammals from MFAS/HFAS and underwater detonation of explosives to the MMPA regulatory definitions of Level A and Level B Harassment and attempt to quantify those effects.

Exposure to MFAS/HFAS

In the subsections below, the following types of impacts are discussed in more detail: Direct physiological impacts, stress responses, acoustic masking and impaired communication, behavioral disturbance, and strandings. An additional useful graphic tool for better understanding the layered nature of potential marine mammal responses to anthropogenic sound is presented in NMFS' January 14, 2009 Programmatic biological opinion on the U.S. Navy's proposal to conduct training exercises in the Southern California Range Complex from January 2009 to January 2014 (available at: *http://www.nmfs.noaa.gov/pr/permits/incidental.htm#applications*). This document presents a conceptual model of the potential responses of endangered and threatened species upon being exposed to MFAS/HFAS and the pathways by which those responses might affect the fitness of individual animals that have been exposed, and the resulting impact on the individual animal's ability to reproduce or survive. Literature supporting the framework, with examples drawn from many taxa (both aquatic and terrestrial) was included in the ''Application of this Approach'' and ''Response Analyses'' sections of that document.

Direct Physiological Effects

Based on the literature, there are two basic ways that MFAS/HFAS might directly result in physical trauma or damage: Noise-induced loss of hearing sensitivity (more commonly-called ''threshold shift'') and acoustically mediated bubble growth. Separately, an animal's behavioral reaction to an acoustic exposure might lead to physiological effects that might ultimately lead to injury or death, which is discussed later in the Stranding section.

Threshold Shift (Noise-Induced Loss of Hearing)

When animals exhibit reduced hearing sensitivity (*i.e.*, sounds must be louder for an animal to recognize them) following exposure to a sufficiently intense sound, it is referred to as a noise-induced threshold shift (TS). An animal can experience temporary threshold shift (TTS) or permanent threshold shift (PTS). TTS can last from minutes or hours to days (*i.e.*, there is

recovery), occurs in specific frequency ranges (*i.e.*, an animal might only have a temporary loss of hearing sensitivity between the frequencies of 1 and 10 kHz), and can be of varying amounts (for example, an animal's hearing sensitivity might be reduced by only 6 dB or reduced by 30 dB). PTS is permanent (*i.e.*, there is no recovery), but also occurs in a specific frequency range and amount as mentioned above for TTS.

The following physiological mechanisms are thought to play a role in inducing auditory TSs: Effects to sensory hair cells in the inner ear that reduce their sensitivity, modification of the chemical environment within the sensory cells, residual muscular activity in the middle ear, displacement of certain inner ear membranes, increased blood flow, and post-stimulatory reduction in both efferent and sensory neural output (Southall *et al.*, 2007). The amplitude, duration, frequency, temporal pattern, and energy distribution of sound exposure all affect the amount of associated TS and the frequency range in which it occurs. As amplitude and duration of sound exposure increase, so, generally, does the amount of TS, along with the recovery time. Human non-impulsive noise exposure guidelines are based on exposures of equal energy (the same SEL) producing equal amounts of hearing impairment regardless of how the sound energy is distributed in time (NIOSH, 1998). Until recently, previous marine mammal TTS studies have also generally supported this equal energy relationship (Southall *et al.*, 2007). Three newer studies, two by Mooney *et al.*, (2009a, 2009b) on a single bottlenose dolphin either exposed to playbacks of Navy MFAS or octave-band noise (4–8 kHz) and one by Kastak *et al.*, (2007) on a single California sea lion exposed to airborne octave-band noise (centered at 2.5 kHz), concluded that for all noise exposure situations the equal energy relationship may not be the best indicator to predict TTS levels. All three of these studies highlight the inherent complexity of TTS in marine mammals, as well the importance of considering exposure duration when assessing impacts. With exposures of equal energy, quieter, longer duration exposures were found to induce greater levels of TTS than those of exposures that were louder and of shorter duration (more similar to MFAS). For intermittent sounds, less TS will occur than from a continuous exposure with the same energy (some recovery will occur between intermittent exposures) (Kryter *et al.*, 1966; Ward, 1997). For example, one short but loud (higher SPL) sound exposure may induce the same impairment as one longer but softer sound, which in turn may cause more impairment than a series of several intermittent softer sounds with the same total energy (Ward, 1997). Additionally, though TTS is temporary, very prolonged exposure to sound strong enough to elicit TTS, or shorter-term exposure to sound levels well above the TTS threshold, can cause PTS, at least in terrestrial mammals (Kryter, 1985) (although in the case of MFAS/HFAS, animals are not expected to be exposed to levels high enough or durations long enough to result in PTS).

PTS is considered auditory injury (Southall *et al.*, 2007). Irreparable damage to the inner or outer cochlear hair cells may cause PTS, however, other mechanisms are also involved, such as exceeding the elastic limits of certain tissues and membranes in the middle and inner ears and resultant changes in the chemical composition of the inner ear fluids (Southall *et al.*, 2007).

Although the published body of scientific literature contains numerous theoretical studies and discussion papers on hearing impairments that can occur with exposure to a loud sound, only a few studies provide empirical information on the levels at which noise-induced loss in hearing sensitivity occurs in nonhuman animals. For cetaceans, published data on the onset of TTS are limited to the captive bottlenose dolphin and beluga (Finneran *et al.,* 2000, 2002b, 2005a; Schlundt *et al.,* 2000; Nachtigall *et al.,* 2003, 2004). For pinnipeds in water, data are limited to Kastak *et al.'s* measurement of TTS in one harbor seal, one elephant seal, and one California sea lion.

Marine mammal hearing plays a critical role in communication with conspecifics, and interpretation of environmental cues for purposes such as predator avoidance and prey capture. Depending on the degree (elevation of threshold in dB), duration (*i.e.,* recovery time), and frequency range of TTS, and the context in which it is experienced, TTS can have effects on marine mammals ranging from discountable to serious (similar to those discussed in auditory masking, below). For example, a marine mammal may be able to readily compensate for a brief, relatively small amount of TTS in a non-critical frequency range that takes place during a time when the animal is traveling through the open ocean, where ambient noise is lower and there are not as many competing sounds present. Alternatively, a larger amount and longer duration of TTS sustained during time when communication is critical for successful mother/calf interactions could have more serious impacts if it were in the same frequency band as the necessary vocalizations and of a severity that it impeded communication. Also, depending on the degree and frequency range, the effects of PTS on an animal could range in severity, although it is considered generally more serious because it is a permanent condition. Of note, reduced hearing sensitivity as a simple function of development and aging has been observed in marine mammals, as well as humans and other taxa (Southall *et al.,* 2007), so we can infer that strategies exist for coping with this condition to some degree, though likely not without cost. There is no empirical evidence that exposure to MFAS/HFAS can cause PTS in any marine mammals; instead the probability of PTS has been inferred from studies of TTS (*see* Richardson *et al.,* 1995).

Acoustically Mediated Bubble Growth

One theoretical cause of injury to marine mammals is rectified diffusion (Crum and Mao, 1996), the process of increasing the size of a bubble by exposing it to a sound field. This process could be facilitated if the environment in which the ensonified bubbles exist is supersaturated with gas. Repetitive diving by marine mammals can cause the blood and some tissues to accumulate gas to a greater degree than is supported by the surrounding environmental pressure (Ridgway and Howard, 1979). The deeper and longer dives of some marine mammals (for example, beaked whales) are theoretically predicted to induce greater supersaturation (Houser *et al.,* 2001b). If rectified diffusion were possible in marine mammals exposed to high-level sound, conditions of tissue supersaturation could theoretically speed the rate and increase the size of bubble growth. Subsequent effects due to tissue trauma and emboli would presumably mirror those observed in humans suffering from decompression sickness.

It is unlikely that the short duration of MFAS pings would be long enough to drive bubble growth to any substantial size, if such a phenomenon occurs. However, an alternative but related hypothesis has also been suggested: Stable bubbles could be destabilized by high-level sound exposures such that bubble growth then occurs through static diffusion of gas out of the tissues. In such a scenario the marine mammal would need to be in a gas-supersaturated state for a long

enough period of time for bubbles to become of a problematic size.

Yet another hypothesis (decompression sickness) has speculated that rapid ascent to the surface following exposure to a startling sound might produce tissue gas saturation sufficient for the evolution of nitrogen bubbles (Jepson *et al.,* 2003; Fernandez *et al.,* 2005). In this scenario, the rate of ascent would need to be sufficiently rapid to compromise behavioral or physiological protections against nitrogen bubble formation. Collectively, these hypotheses can be referred to as ''hypotheses of acoustically mediated bubble growth.''

Although theoretical predictions suggest the possibility for acoustically mediated bubble growth, there is considerable disagreement among scientists as to its likelihood (Piantadosi and Thalmann, 2004; Evans and Miller, 2003). Crum and Mao (1996) hypothesized that received levels would have to exceed 190 dB in order for there to be the possibility of significant bubble growth due to supersaturation of gases in the blood (*i.e.,* rectified diffusion). More recent work conducted by Crum *et al.*, (2005) demonstrated the possibility of rectified diffusion for short duration signals, but at SELs and tissue saturation levels that are highly improbable to occur in diving marine mammals. To date, Energy Levels (ELs) predicted to cause in vivo bubble formation within diving cetaceans have not been evaluated (NOAA, 2002b). Although it has been argued that traumas from some recent beaked whale strandings are consistent with gas emboli and bubble-induced tissue separations (Jepson *et al.,* 2003), there is no conclusive evidence of this. However, Jepson *et al.*, (2003, 2005) and Fernandez *et al.*, (2004, 2005) concluded that in vivo bubble formation, which may be exacerbated by deep, long-duration, repetitive dives may explain why beaked whales appear to be particularly vulnerable to MFAS/HFAS exposures. Further investigation is needed to further assess the potential validity of these hypotheses. More information regarding hypotheses that attempt to explain how behavioral responses to MFAS/HFAS can lead to strandings is included in the Behaviorally Mediated Bubble Growth Section, after the summary of strandings.

Acoustic Masking

Marine mammals use acoustic signals for a variety of purposes, which differ among species, but include communication between individuals, navigation, foraging, reproduction, and learning about their environment (Erbe and Farmer, 2000; Tyack, 2000). Masking, or auditory interference, generally occurs when sounds in the environment are louder than and of a similar frequency to, auditory signals an animal is trying to receive. Masking is a phenomenon that affects animals that are trying to receive acoustic information about their environment, including sounds from other members of their species, predators, prey, and sounds that allow them to orient in their environment. Masking these acoustic signals can disturb the behavior of individual animals, groups of animals, or entire populations.

The extent of the masking interference depends on the spectral, temporal, and spatial relationships between the signals an animal is trying to receive and the masking noise, in addition to other factors. In humans, significant masking of tonal signals occurs as a result of exposure to noise in a narrow band of similar frequencies. As the sound level increases, though, the detection of frequencies above those of the masking stimulus decreases also. This principle is expected to apply to marine mammals as well because of common biomechanical cochlear properties across taxa.

Richardson *et al.*, (1995b) argued that the maximum radius of influence of an industrial noise (including broadband low frequency sound transmission) on a marine mammal is the distance from the source to the point at which the noise can barely be heard. This range is determined by either the hearing sensitivity of the animal or the background noise level present. Industrial masking is most likely to affect some species' ability to detect communication calls and natural sounds (*i.e.,* surf noise, prey noise, *etc.;* Richardson *et al.,* 1995).

The echolocation calls of toothed whales are subject to masking by high frequency sound. Human data indicate low-frequency sound can mask high-frequency sounds (*i.e.,* upward masking). Studies on captive odontocetes by Au *et al.*, (1974, 1985, 1993) indicate that some species may use various processes to reduce masking effects (*e.g.,* adjustments in echolocation call intensity or frequency as a function of background noise conditions). There is also evidence that the directional hearing abilities of odontocetes are useful in reducing masking at the high frequencies these cetaceans use to echolocate, but not at the low-to-moderate frequencies they use to communicate (Zaitseva *et al.,* 1980). A recent study by Nachtigall and Supin (2008) showed that false killer whales adjust their hearing to compensate for ambient sounds and the intensity of returning echolocation signals.

As mentioned previously, the functional hearing ranges of odontocetes, pinnipeds underwater, and mysticetes all encompass the frequencies of the MFAS/HFAS sources used in the Navy's MFAS/HFAS training exercises (although some mysticete's best hearing capacities are likely at frequencies somewhat lower than MFAS). Additionally, in almost all species, vocal repertoires span across the frequencies of these MFAS/HFAS sources used by the Navy. The closer the characteristics of the masking signal to the signal of interest, the more likely masking is to occur. For hull-mounted MFAS/HFAS—which accounts for the largest part of the takes of marine mammals (because of the source strength and number of hours it's conducted), the pulse length and duty cycle of the MFAS/HFAS signal (~1 second pulse twice a minute) makes it less likely that masking will occur as a result.

Impaired Communication

In addition to making it more difficult for animals to perceive acoustic cues in their environment, anthropogenic sound presents separate challenges for animals that are vocalizing. When they vocalize, animals are aware of environmental conditions that affect the ''active space'' of their vocalizations, which is the maximum area within which their vocalizations can be detected before it drops to the level of ambient noise (Brenowitz, 2004; Brumm *et al.,* 2004; Lohr *et al.,* 2003). Animals are also aware of environmental conditions that affect whether listeners can discriminate and recognize their vocalizations from other sounds, which is more important than simply detecting that a vocalization is occurring (Brenowitz, 1982; Brumm *et al.,* 2004; Dooling, 2004, Marten and Marler, 1977; Patricelli *et al.,* 2006). Most animals that vocalize have evolved with an ability to make adjustments to their vocalizations to increase the signal-to-noise ratio, active space, and recognizability/distinguishability of their vocalizations in the face of temporary changes in background noise (Brumm *et al.,* 2004; Patricelli *et al.,* 2006). Vocalizing animals can make one or more of the following adjustments to their vocalizations: Adjust the frequency structure; adjust the amplitude; adjust temporal structure; or adjust temporal delivery (*see* Biological Opinion).

Many animals will combine several of these strategies to compensate for high levels of background noise.

Anthropogenic sounds that reduce the signal-to-noise ratio of animal vocalizations, increase the masked auditory thresholds of animals listening for such vocalizations, or reduce the active space of an animal's vocalizations, impair communication between animals. Most animals that vocalize have evolved strategies to compensate for the effects of short-term or temporary increases in background or ambient noise on their songs or calls. Although the fitness consequences of these vocal adjustments remain unknown, like most other trade-offs animals must make, some of these strategies probably come at a cost (Patricelli *et al.,* 2006). For example, vocalizing more loudly in noisy environments may have energetic costs that decrease the net benefits of vocal adjustment and alter a bird's energy budget (Brumm, 2004; Wood and Yezerinac, 2006). Shifting songs and calls to higher frequencies may also impose energetic costs (Lambrechts, 1996).

Stress Responses

Classic stress responses begin when an animal's central nervous system perceives a potential threat to its homeostasis. That perception triggers stress responses regardless of whether a stimulus actually threatens the animal; the mere perception of a threat is sufficient to trigger a stress response (Moberg, 2000; Sapolsky *et al.,* 2005; Seyle, 1950). Once an animal's central nervous system perceives a threat, it mounts a biological response or defense that consists of a combination of the four general biological defense responses: Behavioral responses, autonomic nervous system responses, neuroendocrine responses, or immune response.

In the case of many stressors, an animal's first and most economical (in terms of biotic costs) response is behavioral avoidance of the potential stressor or avoidance of continued exposure to a stressor. An animal's second line of defense to stressors involves the sympathetic part of the autonomic nervous system and the classical ''fight or flight'' response which includes the cardiovascular system, the gastrointestinal system, the exocrine glands, and the adrenal medulla to produce changes in heart rate, blood pressure, and gastrointestinal activity that humans commonly associate with ''stress.'' These responses have a relatively short duration and may or may not have significant long-term effects on an animal's welfare.

An animal's third line of defense to stressors involves its neuroendocrine or sympathetic nervous systems; the system that has received the most study has been the hypothalmus-pituitary-adrenal system (also known as the HPA axis in mammals or the hypothalamus-pituitary-interrenal axis in fish and some reptiles). Unlike stress responses associated with the autonomic nervous system, virtually all neuro-endocrine functions that are affected by stress—including immune competence, reproduction, metabolism, and behavior—are regulated by pituitary hormones. Stress-induced changes in the secretion of pituitary hormones have been implicated in failed reproduction (Moberg, 1987; Rivier, 1995) and altered metabolism (Elasser *et al.,* 2000), reduced immune competence (Blecha, 2000) and behavioral disturbance. Increases in the circulation of glucocorticosteroids (cortisol, corticosterone, and aldosterone in marine mammals; *see* Romano *et al.,* 2004) have been equated with stress for many years.

The primary distinction between stress (which is adaptive and does not normally place an animal at risk) and distress is the biotic cost of the response. During a stress response, an animal uses glycogen stores that can be quickly replenished once the stress is alleviated. In such circumstances, the cost of the stress response would not pose a risk to the animal's welfare. However, when an animal does not have sufficient energy reserves to satisfy the energetic costs of a stress response, energy resources must be diverted from other biotic functions, which impairs those functions that experience the diversion. For example, when mounting a stress response diverts energy away from growth in young animals, those animals may experience stunted growth. When mounting a stress response diverts energy from a fetus, an animal's reproductive success and its fitness will suffer. In these cases, the animals will have entered a pre-pathological or pathological state which is called ''distress'' (sensu Seyle, 1950) or ''allostatic loading'' (sensu McEwen and Wingfield, 2003). This pathological state will last until the animal replenishes its biotic reserves sufficient to restore normal function.

Relationships between these physiological mechanisms, animal behavior, and the costs of stress responses have also been documented fairly well through controlled experiment; because this physiology exists in every vertebrate that has been studied, it is not surprising that stress responses and their costs have been documented in both laboratory and free-living animals (for examples *see*, Holberton *et al.,* 1996; Hood *et al.,* 1998; Jessop *et al.,* 2003; Krausman *et al.,* 2004; Lankford *et al.,* 2005; Reneerkens *et al.,* 2002; Thompson and Hamer, 2000). Although no information has been collected on the physiological responses of marine mammals to exposure to anthropogenic sounds, studies of other marine animals and terrestrial animals would lead us to expect some marine mammals to experience physiological stress responses and, perhaps, physiological responses that would be classified as ''distress'' upon exposure to high frequency, mid-frequency and low-frequency sounds.

For example, Jansen (1998) reported on the relationship between acoustic exposures and physiological responses that are indicative of stress responses in humans (for example, elevated respiration and increased heart rates). Jones (1998) reported on reductions in human performance when faced with acute, repetitive exposures to acoustic disturbance. Trimper *et al.,* (1998) reported on the physiological stress responses of osprey to low-level aircraft noise while Krausman *et al.,* (2004) reported on the auditory and physiology stress responses of endangered Sonoran pronghorn to military overflights. Smith *et al.,* (2004a, 2004b) identified noise-induced physiological transient stress responses in hearing-specialist fish (*i.e.,* goldfish) that accompanied short- and long-term hearing losses. Welch and Welch (1970) reported physiological and behavioral stress responses that accompanied damage to the inner ears of fish and several mammals.

Hearing is one of the primary senses marine mammals use to gather information about their environment and to communicate with conspecifics. Although empirical information on the relationship between sensory impairment (TTS, PTS, and acoustic masking) on marine mammals remains limited, it seems reasonable to assume that reducing an animal's ability to gather information about its environment and to communicate with other members of its species would be stressful for animals that use hearing as their primary sensory mechanism. Therefore, we assume that acoustic exposures sufficient to trigger onset PTS or TTS would be accompanied by physiological stress responses because terrestrial animals exhibit those responses under similar conditions (NRC, 2003). More importantly, marine mammals might experience stress responses at received levels lower than those necessary to trigger onset TTS. Based on empirical studies of the time required to recover from stress

responses (Moberg, 2000), NMFS also assumes that stress responses could persist beyond the time interval required for animals to recover from TTS and might result in pathological and pre-pathological states that would be as significant as behavioral responses to TTS.

Behavioral Disturbance

Behavioral responses to sound are highly variable and context-specific. Many different variables can influence an animal's perception of and response to (nature and magnitude) an acoustic event. An animal's prior experience with a sound or sound source affects whether it is less likely (habituation) or more likely (sensitization) to respond to certain sounds in the future (animals can also be innately pre-disposed to respond to certain sounds in certain ways) (Southall *et al.,* 2007). Related to the sound itself, the perceived nearness of the sound, bearing of the sound (approaching vs. retreating), similarity of a sound to biologically relevant sounds in the animal's environment (*i.e.,* calls of predators, prey, or conspecifics), and familiarity of the sound may affect the way an animal responds to the sound (Southall *et al.,* 2007). Individuals (of different age, gender, reproductive status, *etc.*) among most populations will have variable hearing capabilities, and differing behavioral sensitivities to sounds that will be affected by prior conditioning, experience, and current activities of those individuals. Often, specific acoustic features of the sound and contextual variables (*i.e.,* proximity, duration, or recurrence of the sound or the current behavior that the marine mammal is engaged in or its prior experience), as well as entirely separate factors such as the physical presence of a nearby vessel, may be more relevant to the animal's response than the received level alone.

Exposure of marine mammals to sound sources can result in (but is not limited to) no response or any of the following observable responses: Increased alertness; orientation or attraction to a sound source; vocal modifications; cessation of feeding; cessation of social interaction; alteration of movement or diving behavior; avoidance; habitat abandonment (temporary or permanent); and, in severe cases, panic, flight, stampede, or stranding, potentially resulting in death (Southall *et al.,* 2007). A review of marine mammal responses to anthropogenic sound was first conducted by Richardson (1995). A more recent review (Nowacek *et al.,* 2007) addresses studies conducted since 1995 and focuses on observations where the received sound level of the exposed marine mammal(s) was known or could be estimated. The following sub-sections provide examples of behavioral responses that provide an idea of the variability in behavioral responses that would be expected given the differential sensitivities of marine mammal species to sound and the wide range of potential acoustic sources to which a marine mammal may be exposed. Estimates of the types of behavioral responses that could occur for a given sound exposure should be determined from the literature that is available for each species, or extrapolated from closely related species when no information exists.

Alteration of Diving or Movement—Changes in dive behavior can vary widely. They may consist of increased or decreased dive times and surface intervals as well as changes in the rates of ascent and descent during a dive. Variations in dive behavior may reflect interruptions in biologically significant activities (*e.g.,* foraging) or they may be of little biological significance. Variations in dive behavior may also expose an animal to potentially harmful conditions (*e.g.,* increasing the chance of ship-strike) or may serve as an avoidance response that enhances survivorship. The impact of a variation in diving resulting from an acoustic exposure depends on what the animal is doing at the time of the exposure and the type and magnitude of the response.

Nowacek *et al.,* (2004) reported disruptions of dive behaviors in foraging North Atlantic right whales when exposed to an alerting stimulus, an action, they noted, that could lead to an increased likelihood of ship-strike. However, the whales did not respond to playbacks of either right whale social sounds or vessel noise, highlighting the importance of the sound characteristics in producing a behavioral reaction. Conversely, Indo-Pacific humpback dolphins have been observed to dive for longer periods of time in areas where vessels were present and/or approaching (Ng and Leung, 2003). In both of these studies, the influence of the sound exposure cannot be decoupled from the physical presence of a surface vessel, thus complicating interpretations of the relative contribution of each stimulus to the response. Indeed, the presence of surface vessels, their approach and speed of approach, seemed to be significant factors in the response of the Indo-Pacific humpback dolphins (Ng and Leung, 2003). Low frequency signals of the Acoustic Thermometry of Ocean Climate (ATOC) sound source were not found to affect dive times of humpback whales in Hawaiian waters (Frankel and Clark, 2000) or to overtly affect elephant seal dives (Costa *et al.,* 2003). They did, however, produce subtle effects that varied in direction and degree among the individual seals, illustrating the equivocal nature of behavioral effects and consequent difficulty in defining and predicting them.

Foraging—Disruption of feeding behavior can be difficult to correlate with anthropogenic sound exposure, so it is usually inferred by observed displacement from known foraging areas, the appearance of secondary indicators (*e.g.,* bubble nets or sediment plumes), or changes in dive behavior. Noise from seismic surveys was not found to impact the feeding behavior in western grey whales off the coast of Russia (Yazvenko *et al.,* 2007) and sperm whales engaged in foraging dives did not abandon dives when exposed to distant signatures of seismic airguns (Madsen *et al.,* 2006). Balaenopterid whales exposed to moderate low-frequency signals similar to the ATOC sound source demonstrated no variation in foraging activity (Croll *et al.,* 2001), whereas five out of six North Atlantic right whales exposed to an acoustic alarm interrupted their foraging dives (Nowacek *et al.,* 2004). Although the received sound pressure level at the animals was similar in the latter two studies, the frequency, duration, and temporal pattern of signal presentation were different. These factors, as well as differences in species sensitivity, are likely contributing factors to the differential response. A determination of whether foraging disruptions incur fitness consequences will require information on or estimates of the energetic requirements of the individuals and the relationship between prey availability, foraging effort and success, and the life history stage of the animal.

Brownell (2004) reported the behavioral responses of western gray whales off the northeast coast of Sakhalin Island to sounds produced by seismic activities in that region. In 1997, the gray whales responded to seismic activities by changing their swimming speed and orientation, respiration rates, and distribution in waters around the seismic surveys. In 2001, seismic activities were conducted in a known feeding area of these whales and the whales left the feeding area and moved to areas farther south in the Sea of Okhotsk. They only returned to the feeding area several days after the seismic activities stopped. The potential fitness consequences of displacing these

whales, especially mother-calf pairs and ''skinny whales,'' outside of their normal feeding area is not known; however, because gray whales, like other large whales, must gain enough energy during the summer foraging season to last them the entire year, sounds or other stimuli that cause them to abandon a foraging area for several days could disrupt their energetics and force them to make trade-offs like delaying their migration south, delaying reproduction, reducing growth, or migrating with reduced energy reserves.

Social relationships—Social interactions between mammals can be affected by noise via the disruption of communication signals or by the displacement of individuals. Disruption of social relationships therefore depends on the disruption of other behaviors (*e.g.,* avoidance, masking, *etc.*). Sperm whales responded to military sonar, apparently from a submarine, by dispersing from social aggregations, moving away from the sound source, remaining relatively silent and becoming difficult to approach (Watkins *et al.,* 1985). Social disruptions must be considered, however, in context of the relationships that are affected. While some disruptions may not have deleterious effects, long-term disruptions of mother/calf pairs or interruption of mating behaviors have the potential to affect the growth and survival or reproductive effort/success of individuals, respectively.

Vocalizations (*also see* Masking section)—Vocal changes in response to anthropogenic noise can occur across the repertoire of sound production modes used by marine mammals, such as whistling, echolocation click production, calling, and singing. Changes may result in response to a need to compete with an increase in background noise or may reflect an increased vigilance or startle response. For example, in the presence of low-frequency active sonar, humpback whales have been observed to increase the length of their ''songs'' (Miller *et al.,* 2000; Fristrup *et al.,* 2003), possibly due to the overlap in frequencies between the whale song and the low-frequency active sonar. A similar compensatory effect for the presence of low-frequency vessel noise has been suggested for right whales; right whales have been observed to shift the frequency content of their calls upward while reducing the rate of calling in areas of increased anthropogenic noise (Parks *et al.,* 2007). Killer whales off the northwestern coast of the United States have been observed to increase the duration of primary calls once a threshold in observing vessel density (*e.g.,* whale watching) was reached, which has been suggested as a response to increased masking noise produced by the vessels (Foote *et al.,* 2004). In contrast, both sperm and pilot whales potentially ceased sound production during the Heard Island feasibility test (Bowles *et al.,* 1994), although it cannot be absolutely determined whether the inability to acoustically detect the animals was due to the cessation of sound production or the displacement of animals from the area.

Avoidance—Avoidance is the displacement of an individual from an area as a result of the presence of a sound. Richardson *et al.,* (1995) noted that avoidance reactions are the most obvious manifestations of disturbance in marine mammals. It is qualitatively different from the flight response, but also differs in the magnitude of the response (*i.e.,* directed movement, rate of travel, *etc.*). Oftentimes avoidance is temporary, and animals return to the area once the noise has ceased. Longer term displacement is possible, however, which can lead to changes in abundance or distribution patterns of the species in the affected region if they do not become acclimated to the presence of the sound (Blackwell *et al.,* 2004; Bejder *et al.,* 2006; Teilmann *et al.,* 2006). Acute avoidance responses have been observed in captive porpoises and pinnipeds exposed to a number of different sound sources (Kastelein *et al.,* 2001; Finneran *et al.,* 2003; Kastelein *et al.,* 2006a; Kastelein *et al.,* 2006b). Short term avoidance of seismic surveys, low-frequency emissions, and acoustic deterrents has also been noted in wild populations of odontocetes (Bowles *et al.,* 1994; Goold, 1996; 1998; Stone *et al.,* 2000; Morton and Symonds, 2002) and to some extent in mysticetes (Gailey *et al.,* 2007), while longer term or repetitive/chronic displacement for some dolphin groups and for manatees has been suggested to be due to the presence of chronic vessel noise (Haviland-Howell *et al.,* 2007; Miksis-Olds *et al.,* 2007).

Maybaum (1993) conducted sound playback experiments to assess the effects of mid-frequency active sonar on humpback whales in Hawaiian waters. Specifically, he exposed focal pods to sounds of a 3.3-kHz sonar pulse, a sonar frequency sweep from 3.1 to 3.6 kHz, and a control (blank) tape while monitoring the behavior, movement, and underwater vocalizations. The two types of sonar signals differed in their effects on the humpback whales, but both resulted in avoidance behavior. The whales responded to the pulse by increasing their distance from the sound source and responded to the frequency sweep by increasing their swimming speeds and track linearity. In the Caribbean, sperm whales avoided exposure to mid-frequency submarine sonar pulses, in the range of 1,000 Hz to 10,000 Hz (IWC 2005).

Kvadsheim *et al.,* (2007) conducted a controlled exposure experiment in which killer whales (*Orcinus orca*) that had been fitted with D-tags were exposed to mid-frequency active sonar (Source A: a 1.0 s upsweep 209 dB @ 1–2 kHz every 10 seconds for 10 minutes; Source B: with a 1.0 s upsweep 197 dB @ 6–7 kHz every 10 s for 10 min). When exposed to Source A, a tagged whale and the group it was traveling with did not appear to avoid the source. When exposed to Source B, the tagged whales along with other whales that had been carousel feeding, ceased feeding during the approach of the sonar and moved rapidly away from the source. When exposed to Source B, Kvadsheim and his co-workers reported that a tagged killer whale seemed to try to avoid further exposure to the sound field by immediately swimming away (horizontally) from the source of the sound; by engaging in a series of erratic and frequently deep dives that seem to take it below the sound field; or by swimming away while engaged in a series of erratic and frequently deep dives. Although the sample sizes in this study are too small to support statistical analysis, the behavioral responses of the orcas were consistent with the results of other studies.

In 2007, the first in the series of behavioral response studies conducted by NMFS and other scientists showed one beaked whale (*Mesoplodon densirostris*) responding to an MFAS playback. The BRS–07 Cruise report indicates that the playback began when the tagged beaked whale was vocalizing at depth (at the deepest part of a typical feeding dive), following a previous control with no sound exposure. The whale appeared to stop clicking significantly earlier than usual, when exposed to mid-frequency signals in the 130–140 dB (rms) range. After a few more minutes of the playback, when the received level reached a maximum of 140–150 dB, the whale ascended on the slow side of normal ascent rates with a longer than normal ascent, at which point the exposure was terminated. The BRS–07 Cruise report notes that the results are from a single experiment and that a greater sample size is needed before robust and definitive conclusions can be drawn (NMFS, 2008)

Flight Response—A flight response is a dramatic change in normal movement to a directed and rapid movement away from the perceived location of a sound

source. Flight responses have been speculated as being a component of marine mammal strandings associated with MFAS activities (Evans and England, 2001). If marine mammals respond to Navy vessels that are transmitting active sonar in the same way that they might respond to a predator, their probability of flight responses should increase when they perceive that Navy vessels are approaching them directly, because a direct approach may convey detection and intent to capture (Burger and Gochfeld, 1981, 1990, Cooper, 1997, 1998). The probability of avoidance responses should also increase as received levels of active sonar increase (and the ship is, therefore, closer) and as ship speeds increase (that is, as approach speeds increase). For example, the probability of flight responses in Dall's sheep *Ovis dalli dalli* (Frid 2001a, 2001b), ringed seals *Phoca hispida* (Born *et al.*, 1999), Pacific brant (*Branta bernicl nigricans*) and Canada geese (*B. Canadensis*) increased as a helicopter or fixed-wing aircraft approached groups of these animals more directly (Ward *et al.*, 1999). Bald eagles (*Haliaeetus leucocephalus*) perched on trees alongside a river were also more likely to flee from a paddle raft when their perches were closer to the river or were closer to the ground (Steidl and Anthony, 1996).

Breathing—Variations in respiration naturally vary with different behaviors and variations in respiration rate as a function of acoustic exposure can be expected to co-occur with other behavioral reactions, such as a flight response or an alteration in diving. However, respiration rates in and of themselves may be representative of annoyance or an acute stress response. Mean exhalation rates of gray whales at rest and while diving were found to be unaffected by seismic surveys conducted adjacent to the whale feeding grounds (Gailey *et al.*, 2007). Studies with captive harbor porpoises showed increased respiration rates upon introduction of acoustic alarms (Kastelein *et al.*, 2001; Kastelein *et al.*, 2006a) and emissions for underwater data transmission (Kastelein *et al.*, 2005). However, exposure of the same acoustic alarm to a striped dolphin under the same conditions did not elicit a response (Kastelein *et al.*, 2006a), again highlighting the importance in understanding species differences in the tolerance of underwater noise when determining the potential for impacts resulting from anthropogenic sound exposure.

Continued Pre-Disturbance Behavior, Habituation, or No Response

Under some circumstances, some of the individual marine mammals that are exposed to active sonar transmissions will continue their normal behavioral activities; in other circumstances, individual animals will become aware of the sonar transmissions at lower received levels and move to avoid additional exposure or exposures at higher received levels (Richardson *et al.*, 1995).

It is difficult to distinguish between animals that continue their pre-disturbance behavior without stress responses, animals that continue their behavior but experience stress responses (that is, animals that cope with disturbance), animals that habituate to disturbance (that is, they may have experienced low-level stress responses initially, but those responses abated over time), and animals that do not respond to the potential disturbance. Watkins (1986) reviewed data on the behavioral reactions of fin, humpback, right and minke whales that were exposed to continuous, broadband low-frequency shipping and industrial noise in Cape Cod Bay. He concluded that underwater sound was the primary cause of behavioral reactions in these species of whales and that the whales responded behaviorally to acoustic stimuli within their respective hearing ranges. Watkins also noted that whales showed the strongest behavioral reactions to sounds in the 15 Hz to 28 kHz range, although negative reactions (avoidance, interruptions in vocalizations, *etc.*) were generally associated with sounds that were either unexpected, too loud, suddenly louder or different, or perceived as being associated with a potential threat (such as an approaching ship on a collision course). In particular, whales seemed to react negatively when they were within 100 m of the source or when received levels increased suddenly in excess of 12 dB relative to ambient sounds. At other times, the whales ignored the source of the signal and all four species habituated to these sounds.

Nevertheless, Watkins concluded that whales ignored most sounds in the background of ambient noise, including the sounds from distant human activities even though these sounds may have had considerable energies at frequencies well within the whales' range of hearing. Further, he noted that of the whales observed, fin whales were the most sensitive of the four species, followed by humpback whales; right whales were the least likely to be disturbed and generally did not react to low-amplitude engine noise. By the end of his period of study, Watkins (1986) concluded that fin and humpback whales have generally habituated to the continuous and broad-band noise of Cape Cod Bay while right whales did not appear to change their response. As mentioned above, animals that habituate to a particular disturbance may have experienced low-level stress responses initially, but those responses abated over time. In most cases, this likely means a lessened immediate potential effect from a disturbance; however, concern exists where the habituation occurs in a potentially more harmful situation, for example: animals may become more vulnerable to vessel strikes once they habituate to vessel traffic (Swingle *et al.*, 1993; Wiley *et al.*, 1995).

Aicken *et al.*, (2005) monitored the behavioral responses of marine mammals to a new low-frequency active sonar system that was being developed for use by the British Navy. During those trials, fin whales, sperm whales, Sowerby's beaked whales, long-finned pilot whales (*Globicephala melas*), Atlantic white-sided dolphins, and common bottlenose dolphins were observed and their vocalizations were recorded. These monitoring studies detected no evidence of behavioral responses that the investigators could attribute to exposure to the low-frequency active sonar during these trials.

Behavioral Responses (Southall et al. (2007))

Southall *et al.*, (2007) reports the results of the efforts of a panel of experts in acoustic research from behavioral, physiological, and physical disciplines that convened and reviewed the available literature on marine mammal hearing and physiological and behavioral responses to human-made sound with the goal of proposing exposure criteria for certain effects. This peer-reviewed compilation of literature is very valuable, though Southall *et al.*, (2007) note that not all data are equal, some have poor statistical power, insufficient controls, and/or limited information on received levels, background noise, and other potentially important contextual variables—such data were reviewed and sometimes used for qualitative illustration but were not included in the quantitative analysis for the criteria recommendations. All of the studies considered, however, contain an estimate of the received sound level when the animal exhibited the indicated response.

In the Southall *et al.*, (2007) publication, for the purposes of

analyzing responses of marine mammals to anthropogenic sound and developing criteria, the authors differentiate between single pulse sounds, multiple pulse sounds, and non-pulse sounds. MFAS/HFAS is considered a non-pulse sound. Southall *et al.*, (2007) summarize the studies associated with low-frequency, mid-frequency, and high-frequency cetacean and pinniped responses to non-pulse sounds, based strictly on received level, in Appendix C of their article (incorporated by reference and summarized in the three paragraphs below).

The studies that address responses of low frequency cetaceans to non-pulse sounds include data gathered in the field and related to several types of sound sources (of varying similarity to MFAS/HFAS) including: vessel noise, drilling and machinery playback, low-frequency M-sequences (sine wave with multiple phase reversals) playback, tactical low-frequency active sonar playback, drill ships, Acoustic Thermometry of Ocean Climate (ATOC) source, and non-pulse playbacks. These studies generally indicate no (or very limited) responses to received levels in the 90 to 120 dB re: 1 μPa range and an increasing likelihood of avoidance and other behavioral effects in the 120 to 160 dB range. As mentioned earlier, though, contextual variables play a very important role in the reported responses and the severity of effects are not linear when compared to received level. Also, few of the laboratory or field datasets had common conditions, behavioral contexts or sound sources, so it is not surprising that responses differ.

The studies that address responses of mid-frequency cetaceans to non-pulse sounds include data gathered both in the field and the laboratory and related to several different sound sources (of varying similarity to MFAS/HFAS) including: Pingers, drilling playbacks, ship and ice-breaking noise, vessel noise, Acoustic Harassment Devices (AHDs), Acoustic Deterrent Devices (ADDs), MFAS, and non-pulse bands and tones. Southall *et al.*, (2007) were unable to come to a clear conclusion regarding the results of these studies. In some cases, animals in the field showed significant responses to received levels between 90 and 120 dB, while in other cases these responses were not seen in the 120 to 150 dB range. The disparity in results was likely due to contextual variation and the differences between the results in the field and laboratory data (animals typically responded at lower levels in the field).

The studies that address responses of high frequency cetaceans to non-pulse sounds include data gathered both in the field and the laboratory and related to several different sound sources (of varying similarity to MFAS/HFAS) including: Pingers, AHDs, and various laboratory non-pulse sounds. All of these data were collected from harbor porpoises. Southall *et al.*, (2007) concluded that the existing data indicate that harbor porpoises are likely sensitive to a wide range of anthropogenic sounds at low received levels (~90–120 dB), at least for initial exposures. All recorded exposures above 140 dB induced profound and sustained avoidance behavior in wild harbor porpoises (Southall *et al.*, 2007). Rapid habituation was noted in some but not all studies. There is no data to indicate whether other high frequency cetaceans are as sensitive to anthropogenic sound as harbor porpoises are.

The studies that address the responses of pinnipeds in water to non-pulse sounds include data gathered both in the field and the laboratory and related to several different sound sources (of varying similarity to MFAS/HFAS) including: AHDs, ATOC, various non-pulse sounds used in underwater data communication; underwater drilling, and construction noise. Few studies exist with enough information to include them in the analysis. The limited data suggested that exposures to non-pulse sounds between 90 and 140 dB generally do not result in strong behavioral responses in pinnipeds in water, but no data exist at higher received levels.

In addition to summarizing the available data, the authors of Southall *et al.*, (2007) developed a severity scaling system with the intent of ultimately being able to assign some level of biological significance to a response. Following is a summary of their scoring system, a comprehensive list of the behaviors associated with each score may be found in the report:

- 0–3 (Minor and/or brief behaviors) includes, but is not limited to: No response; minor changes in speed or locomotion (but with no avoidance); individual alert behavior; minor cessation in vocal behavior; minor changes in response to trained behaviors (in laboratory);
- 4–6 (Behaviors with higher potential to affect foraging, reproduction, or survival) includes, but is not limited to: Moderate changes in speed, direction, or dive profile; brief shift in group distribution; prolonged cessation or modification of vocal behavior (duration > duration of sound), minor or moderate individual and/or group avoidance of sound; brief cessation of reproductive behavior; or refusal to initiate trained tasks (in laboratory);
- 7–9 (Behaviors considered likely to affect the aforementioned vital rates) includes, but is not limited to: Extensive of prolonged aggressive behavior; moderate, prolonged or significant separation of females and dependent offspring with disruption of acoustic reunion mechanisms; long-term avoidance of an area; outright panic, stampede, stranding; threatening or attacking sound source (in laboratory).

In Table 6 we have summarized the scores that Southall *et al.*, (2007) assigned to the papers that reported behavioral responses of low-frequency cetaceans, mid-frequency cetaceans, and pinnipeds in water to non-pulse sounds. This table is included simply to summarize the findings of the studies and opportunistic observations (all of which were capable of estimating received level) that Southall *et al.*, (2007) compiled in the effort to develop acoustic criteria.

	Received RMS Sound Pressure Level (dB re: 1 μPa)											
Response Score	80 to < 90	90 to < 100	100 to < 110	110 to < 120	120 to < 130	130 to < 140	140 to < 150	150 to < 160	160 to < 170	170 to < 180	180 to < 190	190 to <200
9												
8		M	M		M		M				M	M
7						L	L					
6	H	L/H	L/P/H	L/M/H	L/M/H	L	L/H	H	M/H	M		
5			H	H	M							
4				L/M	L/M/P	P	L					
3		M	L/M	L/M	M/P	P						
2			L	L/M	L	L	L					
1			M	M	M							
0	L/H/P	L/H/P	L/M/H	L/M/H/P	L/M/H/P	L	M				M	M

Table 6. Data compiled from three tables from Southall et al. (2007) indicating when marine mammals (low-frequency cetaceans = L, mid-frequency cetaceans = M, high frequency cetaceans = H, and pinnipeds = P) were reported as having a behavioral response of the indicated severity to a non-pulse sound of the indicated received level. As discussed in the text, responses are highly variable and context specific.

Potential Effects of Behavioral Disturbance

The different ways that marine mammals respond to sound are sometimes indicators of the ultimate effect that exposure to a given stimulus will have on the well-being (survival, reproduction, *etc.*) of an animal. There is little quantitative marine mammal data relating the exposure of marine mammals to sound to effects on reproduction or survival, though data exists for terrestrial species to which we can draw comparisons for marine mammals. Several authors have reported that disturbance stimuli cause animals to abandon nesting and foraging sites, Sutherland and Crockford, 1993), cause animals to increase their activity levels and suffer premature deaths or reduced reproductive success when their energy expenditures exceed their energy budgets (Daan *et al.*, 1996, Feare 1976, Giese 1996, Mullner *et al.*, 2004, Waunters *et al.*, 1997), or cause animals to experience higher predation rates when they adopt risk-prone foraging or migratory strategies (Frid and Dill, 2002). Each of these studies addressed the consequences that result when animals shift from one behavioral state (for example, resting or foraging) to another behavioral state (avoidance or escape behavior) because of human disturbance or disturbance stimuli.

One consequence of behavioral avoidance results from changing the energetics of marine mammals because of the energy required to avoid surface vessels or the sound field associated with active sonar (Frid and Dill, 2002). Most animals can avoid that energetic cost by swimming away at slow speeds or those speeds that are at or near the minimum cost of transport (Miksis-Olds, 2006), as has been demonstrated in Florida manatees (Hartman, 1979, Miksis-Olds, 2006).

Those costs increase, however, when animals shift from a resting state, which is designed to conserve an animal's energy, to an active state that consumes energy the animal would have conserved had it not been disturbed. Marine mammals that have been disturbed by anthropogenic noise and vessel approaches are commonly reported to shift from resting behavioral states to active behavioral states, which would imply that they incur an energy cost. Morete *et al.*, (2007) reported that undisturbed humpback whale cows that were accompanied by their calves were frequently observed resting while their calves circled them (milling) and rolling interspersed with dives. When vessels approached, the amount of time cows and calves spent resting and milling, respectively declined significantly. These results are similar to those reported by Scheidat *et al.* (2004) for the humpback whales they observed off the coast of Ecuador.

Constantine and Brunton (2001) reported that bottlenose dolphins in the Bay of Islands, New Zealand only engaged in resting behavior 5% of the time when vessels were within 300 meters compared with 83% of the time when vessels were not present. Miksis-Olds (2006) and Miksis-Olds *et al.* (2005) reported that Florida manatees in Sarasota Bay, Florida, reduced the amount of time they spent milling and increased the amount of time they spent feeding when background noise levels increased. Although the acute costs of these changes in behavior are not likely to exceed an animals' ability to compensate, the chronic costs of these behavioral shifts are uncertain.

Attention is the cognitive process of selectively concentrating on one aspect of an animal's environment while ignoring other things (Posner, 1994). Because animals (including humans) have limited cognitive resources, there is a limit to how much sensory information they can process at any time. The phenomenon called ''attentional capture'' occurs when a stimulus (usually a stimulus that an animal is not concentrating on or attending to) ''captures'' an animal's attention. This shift in attention can occur consciously or unconsciously (for example, when an animal hears sounds that it associates with the approach of a predator) and the shift in attention can be sudden (Dukas, 2002; van Rij, 2007). Once a stimulus has captured an animal's attention, the animal can respond by ignoring the stimulus, assuming a ''watch and wait'' posture, or treat the stimulus as a disturbance and respond accordingly, which includes scanning for the source of the stimulus or ''vigilance'' (Cowlishaw *et al.*, 2004).

Vigilance is normally an adaptive behavior that helps animals determine the presence or absence of predators, assess their distance from conspecifics, or to attend cues from prey (Bednekoff and Lima, 1998; Treves, 2000). Despite those benefits, however, vigilance has a cost of time: when animals focus their attention on specific environmental cues, they are not attending to other activities such a foraging. These costs have been documented best in foraging animals, where vigilance has been shown to substantially reduce feeding rates (Saino, 1994; Beauchamp and Livoreil, 1997; Fritz *et al.*, 2002). Animals will spend more time being vigilant, which may translate to less time foraging or resting, when disturbance stimuli approach them more directly, remain at closer distances, have a greater group size (for example, multiple surface vessels, which, of note, will not be utilized in the NWTRC), or when they co-occur with times that an animal perceives increased risk (for example, when they are giving birth or accompanied by a calf). Most of the published literature, however, suggests that direct approaches will increase the amount of time animals will dedicate to being vigilant. For example, bighorn sheep and Dall's sheep dedicated more time to

being vigilant, and less time resting or foraging, when aircraft made direct approaches over them (Frid, 2001; Stockwell *et al.*, 1991).

Several authors have established that long-term and intense disturbance stimuli can cause population declines by reducing the body condition of individuals that have been disturbed, followed by reduced reproductive success, reduced survival, or both (Daan *et al.*, 1996; Madsen, 1994; White, 1983). For example, Madsen (1994) reported that pink-footed geese (*Anser brachyrhynchus*) in undisturbed habitat gained body mass and had about a 46-percent reproductive success rate compared with geese in disturbed habitat (being consistently scared off the fields on which they were foraging) which did not gain mass and has a 17% reproductive success rate. Similar reductions in reproductive success have been reported for mule deer (*Odocoileus hemionus*) disturbed by all-terrain vehicles (Yarmoloy *et al.*, 1988), caribou disturbed by seismic exploration blasts (Bradshaw *et al.*, 1998), caribou disturbed by low-elevation military jet-fights (Luick *et al.*, 1996), and caribou disturbed by low-elevation jet flights (Harrington and Veitch, 1992). Similarly, a study of elk (*Cervus elaphus*) that were disturbed experimentally by pedestrians concluded that the ratio of young to mothers was inversely related to disturbance rate (Phillips and Alldredge, 2000).

The primary mechanism by which increased vigilance and disturbance appear to affect the fitness of individual animals is by disrupting an animal's time budget and, as a result, reducing the time they might spend foraging and resting (which increases an animal's activity rate and energy demand). For example, a study of grizzly bears (*Ursus horribilis*) reported that bears disturbed by hikers reduced their energy intake by an average of 12 kcal/min (50.2×10^3kJ/min), and spent energy fleeing or acting aggressively toward hikers (White *et al.*, 1999). Alternately, Ridgway *et al.*, (2006) reported that increased vigilance in bottlenose dolphins exposed to sound over a five day period did not cause any sleep deprivation or stress effects such as changes in cortisol or epinephrine levels.

On a related note, many animals perform vital functions, such as feeding, resting, traveling, and socializing, on a diel cycle (24-hr cycle). Substantive behavioral reactions to noise exposure (such as disruption of critical life functions, displacement, or avoidance of important habitat) are more likely to be significant if they last more than one diel cycle or recur on subsequent days (Southall *et al.*, 2007). Consequently, a behavioral response lasting less than one day and not recurring on subsequent days is not considered particularly severe unless it could directly affect reproduction or survival (Southall *et al.*, 2007).

Stranding and Mortality

When a live or dead marine mammal swims or floats onto shore and becomes ''beached'' or incapable of returning to sea, the event is termed a ''stranding'' (Geraci *et al.*, 1999; Perrin and Geraci, 2002; Geraci and Lounsbury, 2005; National Marine Fisheries Service, 2007p). The legal definition for a stranding within the United States is that (A) ''a marine mammal is dead and is (i) on a beach or shore of the United States; or (ii) in waters under the jurisdiction of the United States (including any navigable waters); or (B) a marine mammal is alive and is (i) on a beach or shore of the United States and is unable to return to the water; (ii) on a beach or shore of the United States and, although able to return to the water, is in need of apparent medical attention; or (iii) in the waters under the jurisdiction of the United States (including any navigable waters), but is unable to return to its natural habitat under its own power or without assistance.'' (16 U.S.C. 1421h).

Marine mammals are known to strand for a variety of reasons, such as infectious agents, biotoxicosis, starvation, fishery interaction, ship strike, unusual oceanographic or weather events, sound exposure, or combinations of these stressors sustained concurrently or in series. However, the cause or causes of most strandings are unknown (Geraci *et al.*, 1976; Eaton, 1979, Odell *et al.*, 1980; Best, 1982). Numerous studies suggest that the physiology, behavior, habitat relationships, age, or condition of cetaceans may cause them to strand or might pre-dispose them to strand when exposed to another phenomenon. These suggestions are consistent with the conclusions of numerous other studies that have demonstrated that combinations of dissimilar stressors commonly combine to kill an animal or dramatically reduce its fitness, even though one exposure without the other does not produce the same result (Chroussos, 2000; Creel, 2005; DeVries *et al.*, 2003; Fair and Becker, 2000; Foley *et al.*, 2001; Moberg, 2000; Relyea, 2005a; 2005b, Romero, 2004; Sih *et al.*, 2004).

Several sources have published lists of mass stranding events of cetaceans in an attempt to identify relationships between those stranding events and military active sonar (Hildebrand, 2004; IWC, 2005; Taylor *et al.*, 2004). For example, based on a review of stranding records between 1960 and 1995, the International Whaling Commission (2005) identified ten mass stranding events of Cuvier's beaked whales that had been reported and one mass stranding of four Baird's beaked whale (*Berardius bairdii*). The IWC concluded that, out of eight stranding events reported from the mid-1980s to the summer of 2003, seven had been coincident with the use of MFAS, one of those seven had been associated with the use of tactical low-frequency sonar, and the remaining stranding event had been associated with the use of seismic airguns.

Most of the stranding events reviewed by the IWC involved beaked whales. A mass stranding of Cuvier's beaked whales in the eastern Mediterranean Sea occurred in 1996 (Franzis, 1998) and mass stranding events involving Gervais' beaked whales, Blainville's beaked whales, and Cuvier's beaked whales occurred off the coast of the Canary Islands in the late 1980s (Simmonds and Lopez-Jurado, 1991). The stranding events that occurred in the Canary Islands and Kyparissiakos Gulf in the late 1990s and the Bahamas in 2000 have been the most intensively-studied mass stranding events and have been associated with naval exercises involving the use of MFAS.

Strandings Associated With MFAS

Over the past 12 years, there have been five stranding events coincident with military mid-frequency active sonar use in which exposure to sonar is believed by NMFS and the Navy to have been a contributing factor: Greece (1996); the Bahamas (2000); Madeira (2000); Canary Islands (2002); and Spain (2006). Additionally, in 2004, during the RIMPAC exercises, between 150–200 usually pelagic melon-headed whales occupied the shallow waters of the Hanalei Bay, Kaua'i, Hawaii for over 28 hours. NMFS determined that the mid-frequency sonar was a plausible, if not likely, contributing factor in what may have been a confluence of events that led to the Hanalei Bay stranding. A number of other stranding events coincident with the operation of MFAS including the death of beaked whales or other species (minke whales, dwarf sperm whales, pilot whales) have been reported; however, the majority have not been investigated to the degree necessary to determine the cause of the stranding.

Greece (1996)

Twelve Cuvier's beaked whales stranded atypically (in both time and space) along a 38.2-kilometer strand of the coast of the Kyparissiakos Gulf on May 12 and 13, 1996 (Frantzis, 1998). From May 11 through May 15, the NATO research vessel Alliance was conducting active sonar tests with signals of 600 Hz and 3 kHz and source levels of 228 and 226 dB re: 1 μPa, respectively (D'Amico and Verboom, 1998; D'Spain *et al.*, 2006). The timing and the location of the testing encompassed the time and location of the whale strandings (Frantzis, 1998).

Necropsies of eight of the animals were performed but were limited to basic external examination and sampling of stomach contents, blood, and skin. No ears or organs were collected, and no histological samples were preserved. No apparent abnormalities or wounds were found (Frantzis, 2004). Examination of photos of the animals, taken soon after their death, revealed that the eyes of at least four of the individuals were bleeding. Photos were taken soon after their death (Frantzis, 2004). Stomach contents contained the flesh of cephalopods, indicating that feeding had recently taken place (Frantzis, 1998).

All available information regarding the conditions associated with this stranding event were compiled, and many potential causes were examined including major pollution events, prominent tectonic activity, unusual physical or meteorological events, magnetic anomalies, epizootics, and conventional military activities (International Council for the Exploration of the Sea, 2005a). However, none of these potential causes coincided in time or space with the mass stranding, or could explain its characteristics (International Council for the Exploration of the Sea, 2005a). The robust condition of the animals, plus the recent stomach contents, is inconsistent with pathogenic causes (Frantzis, 2004). In addition, environmental causes can be ruled out as there were no unusual environmental circumstances or events before or during this time period and within the general proximity (Frantzis, 2004).

Because of the rarity of this mass stranding of Cuvier's beaked whales in the Kyparissiakos Gulf (first one in history), the probability for the two events (the military exercises and the strandings) to coincide in time and location, while being independent of each other, was thought to be extremely low (Frantzis, 1998). However, because full necropsies had not been conducted, and no abnormalities were noted, the cause of the strandings could not be precisely determined (Cox *et al.*, 2006). A Bioacoustics Panel convened by NATO concluded that the evidence available did not allow them to accept or reject sonar exposures as a causal agent in these stranding events. Their official finding was ''An acoustic link can neither be clearly established, nor eliminated as a direct or indirect cause for the May 1996 strandings.'' The analysis of this stranding event provided support for, but no clear evidence for, the cause-and-effect relationship of active sonar training activities and beaked whale strandings (Cox *et al.*, 2006).

Bahamas (2000)

NMFS and the Navy prepared a joint report addressing the multi-species stranding in the Bahamas in 2000, which took place within 24 hours of U.S. Navy ships using MFAS as they passed through the Northeast and Northwest Providence Channels on March 15–16, 2000. The ships, which operated both AN/SQS–53C and AN/SQS–56, moved through the channel while emitting MFAS pings approximately every 24 seconds. Of the 17 cetaceans that stranded over a 36-hr period (Cuvier's beaked whales, Blainville's beaked whales, Minke whales, and a spotted dolphin), seven animals died on the beach (5 Cuvier's beaked whales, 1 Blainville's beaked whale, and the spotted dolphin), while the other 10 were returned to the water alive (though their ultimate fate is unknown). As discussed in the Bahamas report (DOC/DON, 2001), there is no likely association between the minke whale and spotted dolphin strandings and the operation of MFAS.

Necropsies were performed on five of the stranded beaked whales. All five necropsied beaked whales were in good body condition, showing no signs of infection, disease, ship strike, blunt trauma, or fishery related injuries, and three still had food remains in their stomachs. Auditory structural damage was discovered in four of the whales, specifically bloody effusions or hemorrhaging around the ears. Bilateral intracochlear and unilateral temporal region subarachnoid hemorrhage, with blood clots in the lateral ventricles, were found in two of the whales. Three of the whales had small hemorrhages in their acoustic fats (located along the jaw and in the melon).

A comprehensive investigation was conducted and all possible causes of the stranding event were considered, whether they seemed likely at the outset or not. Based on the way in which the strandings coincided with ongoing naval activity involving tactical MFAS use, in terms of both time and geography, the nature of the physiological effects experienced by the dead animals, and the absence of any other acoustic sources, the investigation team concluded that MFAS aboard U.S. Navy ships that were in use during the active sonar exercise in question were the most plausible source of this acoustic or impulse trauma to beaked whales. This sound source was active in a complex environment that included the presence of a surface duct, unusual and steep bathymetry, a constricted channel with limited egress, intensive use of multiple, active sonar units over an extended period of time, and the presence of beaked whales that appear to be sensitive to the frequencies produced by these active sonars. The investigation team concluded that the cause of this stranding event was the confluence of the Navy MFAS and these contributory factors working together, and further recommended that the Navy avoid operating MFAS in situations where these five factors would be likely to occur. This report does not conclude that all five of these factors must be present for a stranding to occur, nor that beaked whales are the only species that could potentially be affected by the confluence of the other factors. Based on this, NMFS believes that the operation of MFAS in situations where surface ducts exist, or in marine environments defined by steep bathymetry and/or constricted channels, may increase the likelihood of producing a sound field with the potential to cause cetaceans (especially beaked whales) to strand, and therefore suggests the need for increased vigilance while operating MFAS in these areas, especially when beaked whales (or potentially other deep divers) are likely present.

Madeira, Spain (2000)

From May 10–14, 2000, three Cuvier's beaked whales were found atypically stranded on two islands in the Madeira archipelago, Portugal (Cox *et al.*, 2006). A fourth animal was reported floating in the Madeiran waters by fishermen but did not come ashore (Woods Hole Oceanographic Institution, 2005). Joint NATO amphibious training peacekeeping exercises involving participants from 17 countries and 80 warships, took place in Portugal during May 2–15, 2000.

The bodies of the three stranded whales were examined post mortem (Woods Hole Oceanographic Institution, 2005), though only one of the stranded whales was fresh enough (24 hours after stranding) to be necropsied (Cox *et al.*,

2006). Results from the necropsy revealed evidence of hemorrhage and congestion in the right lung and both kidneys (Cox *et al.*, 2006). There was also evidence of intercochlear and intracranial hemorrhage similar to that which was observed in the whales that stranded in the Bahamas event (Cox *et al.*, 2006). There were no signs of blunt trauma, and no major fractures (Woods Hole Oceanographic Institution, 2005). The cranial sinuses and airways were found to be clear with little or no fluid deposition, which may indicate good preservation of tissues (Woods Hole Oceanographic Institution, 2005).

Several observations on the Madeira stranded beaked whales, such as the pattern of injury to the auditory system, are the same as those observed in the Bahamas strandings. Blood in and around the eyes, kidney lesions, pleural hemorrhages, and congestion in the lungs are particularly consistent with the pathologies from the whales stranded in the Bahamas, and are consistent with stress and pressure related trauma. The similarities in pathology and stranding patterns between these two events suggest that a similar pressure event may have precipitated or contributed to the strandings at both sites (Woods Hole Oceanographic Institution, 2005).

Even though no definitive causal link can be made between the stranding event and naval exercises, certain conditions may have existed in the exercise area that, in their aggregate, may have contributed to the marine mammal strandings (Freitas, 2004): Exercises were conducted in areas of at least 547 fathoms (1,000 m) depth near a shoreline where there is a rapid change in bathymetry on the order of 547 to 3,281 (1,000–6,000 m) fathoms occurring across a relatively short horizontal distance (Freitas, 2004); multiple ships were operating around Madeira, though it is not known if MFAS was used, and the specifics of the sound sources used are unknown (Cox *et al.*, 2006, Freitas, 2004); exercises took place in an area surrounded by land masses separated by less than 35 nm (65 km) and at least 10 nm (19 km) in length, or in an embayment. Exercises involving multiple ships employing MFA near land may produce sound directed towards a channel or embayment that may cut off the lines of egress for marine mammals (Freitas, 2004).

Canary Islands, Spain (2002)

The southeastern area within the Canary Islands is well known for aggregations of beaked whales due to its ocean depths of greater than 547 fathoms (1,000 m) within a few hundred meters of the coastline (Fernandez *et al.*, 2005). On September 24, 2002, 14 beaked whales were found stranded on Fuerteventura and Lanzarote Islands in the Canary Islands (International Council for Exploration of the Sea, 2005a). Seven whales died, while the remaining seven live whales were returned to deeper waters (Fernandez *et al.*, 2005). Four beaked whales were found stranded dead over the next 3 days either on the coast or floating offshore. These strandings occurred within near proximity of an international naval exercise that utilized MFAS and involved numerous surface warships and several submarines. Strandings began about 4 hours after the onset of MFAS activity (International Council for Exploration of the Sea, 2005a; Fernandez *et al.*, 2005).

Eight Cuvier's beaked whales, one Blainville's beaked whale, and one Gervais' beaked whale were necropsied, six of them within 12 hours of stranding (Fernandez *et al.*, 2005). No pathogenic bacteria were isolated from the carcasses (Jepson *et al.*, 2003). The animals displayed severe vascular congestion and hemorrhage especially around the tissues in the jaw, ears, brain, and kidneys, displaying marked disseminated microvascular hemorrhages associated with widespread fat emboli (Jepson *et al.*, 2003; International Council for Exploration of the Sea, 2005a). Several organs contained intravascular bubbles, although definitive evidence of gas embolism *in vivo* is difficult to determine after death (Jepson *et al.*, 2003). The livers of the necropsied animals were the most consistently affected organ, which contained macroscopic gas-filled cavities and had variable degrees of fibrotic encapsulation. In some animals, cavitary lesions had extensively replaced the normal tissue (Jepson *et al.*, 2003). Stomachs contained a large amount of fresh and undigested contents, suggesting a rapid onset of disease and death (Fernandez *et al.*, 2005). Head and neck lymph nodes were enlarged and congested, and parasites were found in the kidneys of all animals (Fernandez *et al.*, 2005).

The association of NATO MFAS use close in space and time to the beaked whale strandings, and the similarity between this stranding event and previous beaked whale mass strandings coincident with active sonar use, suggests that a similar scenario and causative mechanism of stranding may be shared between the events. Beaked whales stranded in this event demonstrated brain and auditory system injuries, hemorrhages, and congestion in multiple organs, similar to the pathological findings of the Bahamas and Madeira stranding events. In addition, the necropsy results of the Canary Islands stranding event lead to the hypothesis that the presence of disseminated and widespread gas bubbles and fat emboli were indicative of nitrogen bubble formation, similar to what might be expected in decompression sickness (Jepson *et al.*, 2003; Fernández *et al.*, 2005).

Spain (2006)

The Spanish Cetacean Society reported an atypical mass stranding of four beaked whales that occurred January 26, 2006, on the southeast coast of Spain, near Mojacar (Gulf of Vera) in the Western Mediterranean Sea. According to the report, two of the whales were discovered the evening of January 26 and were found to be still alive. Two other whales were discovered during the day on January 27, but had already died. The fourth animal was found dead on the afternoon of January 27, a few kilometers north of the first three animals. From January 25–26, 2006, Standing North Atlantic Treaty Organization (NATO) Response Force Maritime Group Two (five of seven ships including one U.S. ship under NATO Operational Control) had conducted active sonar training against a Spanish submarine within 50 nm (93 km) of the stranding site.

Veterinary pathologists necropsied the two male and two female Cuvier's beaked whales. According to the pathologists, the most likely primary cause of this type of beaked whale mass stranding event was anthropogenic acoustic activities, most probably anti-submarine MFAS used during the military naval exercises. However, no positive acoustic link was established as a direct cause of the stranding. Even though no causal link can be made between the stranding event and naval exercises, certain conditions may have existed in the exercise area that, in their aggregate, may have contributed to the marine mammal strandings (Freitas, 2004): exercises were conducted in areas of at least 547 fathoms (1000 m) depth near a shoreline where there is a rapid change in bathymetry on the order of 547 to 3,281 fathoms (1000–6000 m) occurring across a relatively short horizontal distance (Freitas, 2004); multiple ships (in this instance, five) were operating MFAS in the same area over extended periods of time (in this case, 20 hours) in close proximity; Exercises took place in an area surrounded by landmasses, or in an embayment. Exercises involving

multiple ships employing MFAS near land may have produced sound directed towards a channel or embayment that may have cut off the lines of egress for the affected marine mammals (Freitas, 2004).

Hanalei Bay (2004)

On July 3–4, 2004, approximately 150–200 melon-headed whales occupied the shallow waters of the Hanalei Bay, Kaua'i, Hawaii for over 28 hours. Attendees of a canoe blessing observed the animals entering the Bay in a single wave formation at 7 a.m. on July 3, 2004. The animals were observed moving back into the shore from the mouth of the Bay at 9 a.m. The usually pelagic animals milled in the shallow bay and were returned to deeper water with human assistance beginning at 9:30 a.m. on July 4, 2004, and were out of sight by 10:30 a.m.

Only one animal, a calf, was known to have died following this event. The animal was noted alive and alone in the Bay on the afternoon of July 4, 2004 and was found dead in the Bay the morning of July 5, 2004. A full necropsy, magnetic resonance imaging, and computerized tomography examination were performed on the calf to determine the manner and cause of death. The combination of imaging, necropsy and histological analyses found no evidence of infectious, internal traumatic, congenital, or toxic factors. Although cause of death could not be definitively determined, it is likely that maternal separation, poor nutritional condition, and dehydration contributed to the final demise of the animal. Although we do not know when the calf was separated from its mother, the movement into the Bay, the milling and re-grouping may have contributed to the separation or lack of nursing especially if the maternal bond was weak or this was a primiparous calf.

Environmental factors, abiotic and biotic, were analyzed for any anomalous occurrences that would have contributed to the animals entering and remaining in Hanalei Bay. The Bay's bathymetry is similar to many other sites within the Hawaiian Island chain and dissimilar to sites that have been associated with mass strandings in other parts of the United States. The weather conditions appeared to be normal for that time of year with no fronts or other significant features noted. There was no evidence of unusual distribution or occurrence of predator or prey species, or unusual harmful algal blooms. Weather patterns and bathymetry that have been associated with mass strandings elsewhere were not found to occur in this instance.

A separate event involving melon-headed whales and rough-toothed dolphins took place over the same period of time in the Northern Mariana Islands (Jefferson *et al.*, 2006), which is several thousand miles from Hawaii. Some 500–700 melon-headed whales came into Sasanhaya Bay on 4 July 2004 on the island of Rota and then left of their own accord after 5.5 hours; no known active sonar transmissions occurred in the vicinity of that event. Global reports of these types of events or sightings are of great interest to the scientific community and continuing efforts to enhance reporting in island nations will contribute to our increased understanding of animal behavior and potential causes of stranding events. Exactly what, if any, relationship this event has to the simultaneous events in Hawaii and whether they might be related to some common factor (*e.g.*, there was a full moon on July 2, 2004) is and will likely remain unknown. However, these two synchronous, nearshore events involving a rarely-sighted species are curious and may point to the range of potential contributing factors for which we lack detailed understanding and which the authors acknowledged might have played some role in the ''confluence of events'' in Hanalei Bay.

The Hanalei event was spatially and temporally correlated with RIMPAC. Official sonar training and tracking exercises in the Pacific Missile Range Facility (PMRF) warning area did not commence until approximately 8 a.m. on July 3 and were thus ruled out as a possible trigger for the initial movement into the Bay.

However, six naval surface vessels transiting to the operational area on July 2 intermittently transmitted active sonar (for approximately 9 hours total from 1:15 p.m. to 12:30 a.m.) as they approached from the south. The potential for these transmissions to have triggered the whales' movement into Hanalei Bay was investigated. Analyses with the information available indicated that animals to the south and east of Kaua'i could have detected active sonar transmissions on July 2, and reached Hanalei Bay on or before 7 a.m. on July 3, 2004. However, data limitations regarding the position of the whales prior to their arrival in the Bay, the magnitude of sonar exposure, behavioral responses of melon-headed whales to acoustic stimuli, and other possible relevant factors preclude a conclusive finding regarding the role of sonar in triggering this event. Propagation modeling suggest that transmissions from sonar use during the July 3 exercise in the PMRF warning area may have been detectable at the mouth of the Bay. If the animals responded negatively to these signals, it may have contributed to their continued presence in the Bay. The U.S. Navy ceased all active sonar transmissions during exercises in this range on the afternoon of July 3, 2004. Subsequent to the cessation of sonar use, the animals were herded out of the Bay.

While causation of this stranding event may never be unequivocally determined, we consider the active sonar transmissions of July 2–3, 2004, a plausible, if not likely, contributing factor in what may have been a confluence of events. This conclusion is based on: (1) The evidently anomalous nature of the stranding; (2) its close spatiotemporal correlation with wide-scale, sustained use of sonar systems previously associated with stranding of deep-diving marine mammals; (3) the directed movement of two groups of transmitting vessels toward the southeast and southwest coast of Kauai; (4) the results of acoustic propagation modeling and an analysis of possible animal transit times to the Bay; and (5) the absence of any other compelling causative explanation. The initiation and persistence of this event may have resulted from an interaction of biological and physical factors. The biological factors may have included the presence of an apparently uncommon, deep-diving cetacean species (and possibly an offshore, non-resident group), social interactions among the animals before or after they entered the Bay, and/or unknown predator or prey conditions. The physical factors may have included the presence of nearby deep water, multiple vessels transiting in a directed manner while transmitting active sonar over a sustained period, the presence of surface sound ducting conditions, and/or intermittent and random human interactions while the animals were in the Bay.

Association Between Mass Stranding Events and Exposure to MFAS

Several authors have noted similarities between some of these stranding incidents: They occurred in islands or archipelagoes with deep water nearby, several appeared to have been associated with acoustic waveguides like surface ducting, and the sound fields created by ships transmitting MFAS (Cox *et al.*, 2006, D'Spain *et al.*, 2006). Although Cuvier's beaked whales have been the most common species involved in these stranding events (81% of the total number of stranded animals), other beaked whales (including *Mesoplodon europeaus, M. densirostris*, and

Hyperoodon ampullatus) comprise 14% of the total. Other species, such as Kogia breviceps, have stranded in association with the operation of MFAS, but in much lower numbers and less consistently than beaked whales.

Based on the evidence available, however, we cannot determine whether (a) Cuvier's beaked whale is more prone to injury from high-intensity sound than other species, (b) their behavioral responses to sound makes them more likely to strand, or (c) they are more likely to be exposed to MFAS than other cetaceans (for reasons that remain unknown). Because the association between active sonar exposures and marine mammals mass stranding events is not consistent—some marine mammals strand without being exposed to active sonar and some sonar transmissions are not associated with marine mammal stranding events despite their co-occurrence—other risk factors or a grouping of risk factors probably contribute to these stranding events.

Behaviorally Mediated Responses to MFAS That May Lead to Stranding

Although the confluence of Navy MFAS with the other contributory factors noted in the report was identified as the cause of the 2000 Bahamas stranding event, the specific mechanisms that led to that stranding (or the others) are not understood, and there is uncertainty regarding the ordering of effects that led to the stranding. It is unclear whether beaked whales were directly injured by sound (acoustically mediated bubble growth, addressed above) prior to stranding or whether a behavioral response to sound occurred that ultimately caused the beaked whales to be injured and to strand.

Although causal relationships between beaked whale stranding events and active sonar remain unknown, several authors have hypothesized that stranding events involving these species in the Bahamas and Canary Islands may have been triggered when the whales changed their dive behavior in a startled response to exposure to active sonar or to further avoid exposure (Cox *et al.*, 2006; Rommel *et al.*, 2006). These authors proposed three mechanisms by which the behavioral responses of beaked whales upon being exposed to active sonar might result in a stranding event. These include: gas bubble formation caused by excessively fast surfacing; remaining at the surface too long when tissues are supersaturated with nitrogen; or diving prematurely when extended time at the surface is necessary to eliminate excess nitrogen. More specifically, beaked whales that occur in deep waters that are in close proximity to shallow waters (for example, the ''canyon areas'' that are cited in the Bahamas stranding event; *see* D'Spain and D'Amico, 2006), may respond to active sonar by swimming into shallow waters to avoid further exposures and strand if they were not able to swim back to deeper waters. Second, beaked whales exposed to active sonar might alter their dive behavior. Changes in their dive behavior might cause them to remain at the surface or at depth for extended periods of time which could lead to hypoxia directly by increasing their oxygen demands or indirectly by increasing their energy expenditures (to remain at depth) and increase their oxygen demands as a result. If beaked whales are at depth when they detect a ping from an active sonar transmission and change their dive profile, this could lead to the formation of significant gas bubbles, which could damage multiple organs or interfere with normal physiological function (Cox *et al.*, 2006; Rommel *et al.*, 2006; Zimmer and Tyack, 2007). Baird *et al.*, (2005) found that slow ascent rates from deep dives and long periods of time spent within 50 m of the surface were typical for both Cuvier's and Blainville's beaked whales, the two species involved in mass strandings related to naval MFAS. These two behavioral mechanisms may be necessary to purge excessive dissolved nitrogen concentrated in their tissues during their frequent long dives (Baird *et al.*, 2005). Baird *et al.*, (2005) further suggests that abnormally rapid ascents or premature dives in response to high-intensity active sonar could indirectly result in physical harm to the beaked whales, through the mechanisms described above (gas bubble formation or non-elimination of excess nitrogen).

Because many species of marine mammals make repetitive and prolonged dives to great depths, it has long been assumed that marine mammals have evolved physiological mechanisms to protect against the effects of rapid and repeated decompressions. Although several investigators have identified physiological adaptations that may protect marine mammals against nitrogen gas supersaturation (alveolar collapse and elective circulation; Kooyman *et al.*, 1972; Ridgway and Howard, 1979), Ridgway and Howard (1979) reported that bottlenose dolphins (*Tursiops truncatus*) that were trained to dive repeatedly had muscle tissues that were substantially supersaturated with nitrogen gas. Houser *et al.* (2001) used these data to model the accumulation of nitrogen gas within the muscle tissue of other marine mammal species and concluded that cetaceans that dive deep and have slow ascent or descent speeds would have tissues that are more supersaturated with nitrogen gas than other marine mammals. Based on these data, Cox *et al.*, (2006) hypothesized that a critical dive sequence might make beaked whales more prone to stranding in response to acoustic exposures. The sequence began with (1) very deep (to depths of up to 2 kilometers) and long (as long as 90 minutes) foraging dives with (2) relatively slow, controlled ascents, followed by (3) a series of ''bounce'' dives between 100 and 400 meters in depth (*also see* Zimmer and Tyack, 2007). They concluded that acoustic exposures that disrupted any part of this dive sequence (for example, causing beaked whales to spend more time at surface without the bounce dives that are necessary to recover from the deep dive) could produce excessive levels of nitrogen supersaturation in their tissues, leading to gas bubble and emboli formation that produces pathologies similar to decompression sickness.

Recently, Zimmer and Tyack (2007) modeled nitrogen tension and bubble growth in several tissue compartments for several hypothetical dive profiles and concluded that repetitive shallow dives (defined as a dive where depth does not exceed the depth of alveolar collapse, approximately 72 m for *Ziphius*), perhaps as a consequence of an extended avoidance reaction to active sonar sound, could pose a risk for decompression sickness and that this risk should increase with the duration of the response. Their models also suggested that unrealistically rapid ascent rates of ascent from normal dive behaviors are unlikely to result in supersaturation to the extent that bubble formation would be expected. Tyack *et al.*, (2006) suggested that emboli observed in animals exposed to MFAS (Jepson *et al.*, 2003; Fernandez *et al.*, 2005) could stem from a behavioral response that involves repeated dives shallower than the depth of lung collapse. Given that nitrogen gas accumulation is a passive process (*i.e.* nitrogen is metabolically inert), a bottlenose dolphin was trained to repetitively dive a profile predicted to elevate nitrogen saturation to the point that nitrogen bubble formation was predicted to occur. However, inspection of the vascular system of the dolphin via ultrasound did not demonstrate the formation of asymptomatic nitrogen gas bubbles (Houser *et al.*, 2007). Baird *et*

al., (2008), in a beaked whale tagging study off Hawaii, showed that deep dives are equally common during day or night, but ''bounce dives'' are typically a daytime behavior, possibly associated with visual predator avoidance (Baird *et al.*, 2008). This may indicate that ''bounce dives'' are associated with something other than behavioral regulation of dissolved nitrogen levels, which would be necessary day and night.

Despite the many theories involving bubble formation (both as a direct cause of injury (*see* Acoustically Mediated Bubble Growth Section) and an indirect cause of stranding (See Behaviorally Mediated Bubble Growth Section), Southall *et al.*, (2007) summarizes that there is either scientific disagreement or a lack of information regarding each of the following important points: (1) Received acoustical exposure conditions for animals involved in stranding events; (2) pathological interpretation of observed lesions in stranded marine mammals; (3) acoustic exposure conditions required to induce such physical trauma directly; (4) whether noise exposure may cause behavioral reactions (such as atypical diving behavior) that secondarily cause bubble formation and tissue damage; and (5) the extent the post mortem artifacts introduced by decomposition before sampling, handling, freezing, or necropsy procedures affect interpretation of observed lesions.

Of note, no major ASW training exercises are proposed to be conducted in the NWTRC. The exercises utilizing MFAS will not utilize more than one surface vessel MFAS source at once. Additionally, while beaked whales may be present in the NWTRC where surface duct and steep bathymetry (in the form of sea mounts) characteristics exist, none of the training events will take place in a location having a constricted channel less than 35 miles wide or with limited egress similar to the Bahamas. Moreover, no sonar is proposed to be used in the Inshore area east of the mouth of the Strait of Juan de Fuca. Additionally, only approximately 110 hours of the highest power surface vessel MFAS use will be conducted annually (in short duration 1.5 hour exercises) in the NWTRC per year. Although the five environmental factors believed to have contributed to the Bahamas stranding (at least 3 surface vessel MFAS sources operating simultaneously or in conjunction with one another, beaked whale presence, surface ducts, steep bathymetry, and constricted channels with limited egress) will not be present during exercises in NWTRC, NMFS recommends caution when either steep bathymetry, surface ducting conditions, or a constricted channel is present when mid-frequency active sonar is employed and cetaceans (especially beaked whales) are present.

Exposure to Underwater Detonation of Explosives

Some of the Navy's training exercises include the underwater detonation of explosives. For many of the exercises discussed, inert ordnance is used for a subset of the exercises. For exercises that involve ''shooting'' at a target that is above the surface of the water, underwater explosions only occur when the target is missed, which is the minority of the time (the Navy has historical hit/miss ratios and uses them in their exposure estimates). The underwater explosion from a weapon would send a shock wave and blast noise through the water, release gaseous by-products, create an oscillating bubble, and cause a plume of water to shoot up from the water surface. The shock wave and blast noise are of most concern to marine animals. Depending on the intensity of the shock wave and size, location, and depth of the animal, an animal can be injured, killed, suffer non-lethal physical effects, experience hearing related effects with or without behavioral responses, or exhibit temporary behavioral responses or tolerance from hearing the blast sound. Generally, exposures to higher levels of impulse and pressure levels would result in worse impacts to an individual animal.

Injuries resulting from a shock wave take place at boundaries between tissues of different density. Different velocities are imparted to tissues of different densities, and this can lead to their physical disruption. Blast effects are greatest at the gas-liquid interface (Landsberg, 2000). Gas-containing organs, particularly the lungs and gastrointestinal tract, are especially susceptible (Goertner, 1982; Hill, 1978; Yelverton *et al.*, 1973). In addition, gas-containing organs including the nasal sacs, larynx, pharynx, trachea, and lungs may be damaged by compression/expansion caused by the oscillations of the blast gas bubble (Reidenberg and Laitman, 2003). Intestinal walls can bruise or rupture, with subsequent hemorrhage and escape of gut contents into the body cavity. Less severe gastrointestinal tract injuries include contusions, petechiae (small red or purple spots caused by bleeding in the skin), and slight hemorrhaging (Yelverton *et al.*, 1973).

Because the ears are the most sensitive to pressure, they are the organs most sensitive to injury (Ketten, 2000). Sound-related trauma associated with blast noise can be theoretically distinct from injury from the shock wave, particularly farther from the explosion. If an animal is able to hear a noise, at some level it can fatigue or damage its hearing by causing decreased sensitivity (Ketten, 1995) (*See* Noise-induced Threshold Shift Section above). Sound-related trauma can be lethal or sublethal. Lethal impacts are those that result in immediate death or serious debilitation in or near an intense source and are not, technically, pure acoustic trauma (Ketten, 1995). Sublethal impacts include hearing loss, which is caused by exposures to perceptible sounds. Severe damage (from the shock wave) to the ears includes tympanic membrane rupture, fracture of the ossicles, damage to the cochlea, hemorrhage, and cerebrospinal fluid leakage into the middle ear. Moderate injury implies partial hearing loss due to tympanic membrane rupture and blood in the middle ear. Permanent hearing loss also can occur when the hair cells are damaged by one very loud event, as well as by prolonged exposure to a loud noise or chronic exposure to noise. The level of impact from blasts depends on both an animal's location and, at outer zones, on its sensitivity to the residual noise (Ketten, 1995).

There have been fewer studies addressing the behavioral effects of explosives on marine mammals than MFAS/HFAS. However, though the nature of the sound waves emitted from an explosion is different (in shape and rise time) from MFAS/HFAS, we still anticipate the same sorts of behavioral responses (*see* Exposure to MFAS/HFAS: Behavioral Disturbance Section) to result from repeated explosive detonations (a smaller range of likely less severe responses would be expected to occur as a result of exposure to a single explosive detonation).

Potential Effects of Vessel Movement and Collisions

Vessel movement in the vicinity of marine mammals has the potential to result in either a behavioral response or a direct physical interaction. Both scenarios are discussed below.

Vessel Movement

There are limited data concerning marine mammal behavioral responses to vessel traffic and vessel noise, and a lack of consensus among scientists with respect to what these responses mean or whether they result in short-term or long-term adverse effects. In those cases where there is a busy shipping lane or where there is large amount of vessel

traffic, marine mammals may experience acoustic masking (Hildebrand, 2005) if they are present in the area (*e.g.*, killer whales in Puget Sound; Foote *et al.,* 2004; Holt *et al.*, 2008). In cases where vessels actively approach marine mammals (*e.g.*, whale watching or dolphin watching boats), scientists have documented that animals exhibit altered behavior such as increased swimming speed, erratic movement, and active avoidance behavior (Bursk, 1983; Acevedo, 1991; Baker and MacGibbon, 1991; Trites and Bain, 2000; Williams *et al.*, 2002; Constantine *et al.*, 2003), reduced blow interval (Ritcher *et al.*, 2003), disruption of normal social behaviors (Lusseau, 2003; 2006), and the shift of behavioral activities which may increase energetic costs (Constantine *et al.*, 2003; 2004)). A detailed review of marine mammal reactions to ships and boats is available in Richardson *et al.* (1995). For each of the marine mammals taxonomy groups, Richardson *et al.* (1995) provided the following assessment regarding cetacean reactions to vessel traffic:

Toothed whales: ''In summary, toothed whales sometimes show no avoidance reaction to vessels, or even approach them. However, avoidance can occur, especially in response to vessels of types used to chase or hunt the animals. This may cause temporary displacement, but we know of no clear evidence that toothed whales have abandoned significant parts of their range because of vessel traffic.''

Baleen whales: ''When baleen whales receive low-level sounds from distant or stationary vessels, the sounds often seem to be ignored. Some whales approach the sources of these sounds. When vessels approach whales slowly and non-aggressively, whales often exhibit slow and inconspicuous avoidance maneuvers. In response to strong or rapidly changing vessel noise, baleen whales often interrupt their normal behavior and swim rapidly away. Avoidance is especially strong when a boat heads directly toward the whale.''

It is important to recognize that behavioral responses to stimuli are complex and influenced to varying degrees by a number of factors such as species, behavioral contexts, geographical regions, source characteristics (moving or stationary, speed, direction, *etc.*), prior experience of the animal, and physical status of the animal. For example, studies have shown that beluga whales reacted differently when exposed to vessel noise and traffic. In some cases, nave beluga whales exhibited rapid swimming from ice-breaking vessels up to 80 km away, and showed changes in surfacing, breathing, diving, and group composition in the Canadian high Arctic where vessel traffic is rare (Finley *et al.*, 1990). In other cases, beluga whales were more tolerant of vessels, but differentially responsive by reducing their calling rates, to certain vessels and operating characteristics (especially older animals) in the St. Lawrence River where vessel traffic is common (Blane and Jaakson, 1994). In Bristol Bay, Alaska, beluga whales continued to feed when surrounded by fishing vessels and resisted dispersal even when purposefully harassed (Fish and Vania, 1971).

In reviewing more than 25 years of whale observation data, Watkins (1986) concluded that whale reactions to vessel traffic were ''modified by their previous experience and current activity: habituation often occurred rapidly, attention to other stimuli or preoccupation with other activities sometimes overcame their interest or wariness of stimuli.'' Watkins noticed that over the years of exposure to ships in the Cape Cod area, minke whales (*Balaenoptera acutorostrata*) changed from frequent positive (such as approaching vessels) interest to generally uninterested reactions; finback whales (*B. physalus*) changed from mostly negative (such as avoidance) to uninterested reactions; right whales (*Eubalaena glacialis*) apparently continued the same variety of responses (negative, uninterested, and positive responses) with little change; and humpbacks (*Megaptera novaeangliae*) dramatically changed from mixed responses that were often negative to often strongly positive reactions. Watkins (1986) summarized that ''whales near shore, even in regions with low vessel traffic, generally have become less wary of boats and their noises, and they have appeared to be less easily disturbed than previously. In particular locations with intense shipping and repeated approaches by boats (such as the whale-watching areas of Stellwagen Bank), more and more whales had P [positive] reactions to familiar vessels, and they also occasionally approached other boats and yachts in the same ways.''

The Northwest Training Range Complex is well traveled by a variety of commercial and recreational vessels and a fair portion of the marine mammals in the area are expected to be habituated to vessel noise. Washington state handles seven percent of the country's exports and six percent of its imports. Cruise ships make daily use of the Seattle Port. A substantial volume of small boat traffic, primarily recreational, occurs throughout Puget Sound, which has 244 marinas with 39,400 moorage slips and another 331 launch sites for smaller boats.

As described in the Description of the Specified Activity section, training exercises involving vessel movements occur intermittently and are variable in duration, ranging from a few hours up to 2 weeks. During training, speeds vary and depend on the specific type of activity, although 10–14 knots is considered the typical speed. Approximately 490 activities that involve Navy vessels occur within the Study Area during a typical year. Training activities are widely dispersed throughout the large OPAREA, which encompasses 122,468 nm^2 (420,054 km^2). Consequently, the density of Navy ships within the Study Area at any given time is low.

Moreover, naval vessels transiting the study area or engaging in the training exercises will not actively or intentionally approach a marine mammal or change speed drastically. While in transit, naval vessels will be alert at all times, use extreme caution, and proceed at a ''safe speed'' so that the vessel can take proper and effective action to avoid a collision with any marine animal and can be stopped within a distance appropriate to the prevailing circumstances and conditions. When whales have been sighted in the area, Navy vessels will increase vigilance and take reasonable and practicable actions to avoid collisions and activities that might result in close interaction of naval assets and marine mammals. Actions may include changing speed and/or direction and would be dictated by environmental and other conditions (*e.g.,* safety, weather).

Although the radiated sound from Navy vessels will be audible to marine mammals over a large distance, it is unlikely that animals will respond behaviorally (in a manner that NMFS would consider MMPA harassment) to low-level distant shipping noise as the animals in the area are likely to be habituated to such noises (Nowacek *et al.,* 2004). In light of these facts, NMFS does not expect the Navy's vessel movements to result in Level B harassment.

Vessel Strike

Commercial and Navy ship strikes of cetaceans can cause major wounds, which may lead to the death of the animal. An animal at the surface could be struck directly by a vessel, a surfacing animal could hit the bottom of a vessel, or an animal just below the surface could be cut by a vessel's

propeller. The severity of injuries typically depends on the size and speed of the vessel (Knowlton and Kraus, 2001; Laist *et al.* 2001; Vanderlaan and Taggart, 2007).

The most vulnerable marine mammals are those that spend extended periods of time at the surface in order to restore oxygen levels within their tissues after deep dives (for example, the sperm whale). In addition, some baleen whales, such as the North Atlantic right whale seem generally unresponsive to vessel sound, making them more susceptible to vessel collisions (Nowacek *et al.,* 2004). These species are primarily large, slow-moving whales. Smaller marine mammals (for example, bottlenose dolphin) move quickly through the water column and are often seen riding the bow wave of large ships. Marine mammal responses to vessels may include avoidance and changes in dive pattern (NRC, 2003).

An examination of all known ship strikes from all shipping sources (civilian and military) indicates vessel speed is a principal factor in whether a vessel strike results in death (Knowlton and Kraus, 2001; Laist *et al.,* 2001, Jensen and Silber, 2003; Vanderlaan and Taggart, 2007). In assessing records in which vessel speed was known, Laist *et al.* (2001) found a direct relationship between the occurrence of a whale strike and the speed of the vessel involved in the collision. The authors concluded that most deaths occurred when a vessel was traveling in excess of 13 knots.

Jensen and Silber (2003) detailed 292 records of known or probable ship strikes of all large whale species from 1975 to 2002. Of these, vessel speed at the time of collision was reported for 58 cases. Of these cases, 39 (or 67%) resulted in serious injury or death (19 or 33% resulted in serious injury as determined by blood in the water, propeller gashes or severed tailstock, and fractured skull, jaw, vertebrae, hemorrhaging, massive bruising or other injuries noted during necropsy and 20 to 35% resulted in death). Operating speeds of vessels that struck various species of large whales ranged from 2 to 51 knots. The majority (79%) of these strikes occurred at speeds of 13 knots or greater. The average speed that resulted in serious injury or death was 18.6 knots. Pace and Silber (2005) found that the probability of death or serious injury increased rapidly with increasing vessel speed. Specifically, the predicted probability of serious injury or death increased from 45% to 75% as vessel speed increased from 10 to 14 knots, and exceeded 90% at 17 knots. Higher speeds during collisions result in greater force of impact, but higher speeds also appear to increase the chance of severe injuries or death by pulling whales toward the vessel. Computer simulation modeling showed that hydrodynamic forces pulling whales toward the vessel hull increase with increasing speed (Clyne, 1999, Knowlton *et al.,* 1995).

The Jensen and Silber (2003) report notes that the database represents a minimum number of collisions, because the vast majority probably go undetected or unreported. In contrast, Navy vessels are likely to detect any strike that does occur, and they are required to report all ship strikes involving marine mammals. Overall, the percentages of Navy traffic relative to overall large shipping traffic are very small (on the order of 2%).

The ability of a ship to avoid a collision and to detect a collision depends on a variety of factors, including environmental conditions, ship design, size, and manning. The majority of ships participating in NWTRC training activities have a number of advantages for avoiding ship strikes as compared to most commercial merchant vessels, including the following:

- Navy ships have their bridges positioned forward, offering good visibility ahead of the bow.
- Crew size is much larger than that of merchant ships allowing for more potential observers on the bridge.
- Dedicated lookouts are posted during a training activity scanning the ocean for anything detectable in the water; anything detected is reported to the Officer of the Deck.
- Navy lookouts receive extensive training including Marine Species Awareness Training designed to provide marine species detection cues and information necessary to detect marine mammals.
- Navy ships are generally much more maneuverable than commercial merchant vessels.

The Navy has adopted mitigation measures to reduce the potential for collisions with surfaced marine mammals. For a thorough discussion of mitigation measures, please see the Mitigation section. Briefly, these measures include:

- At all times when vessels are underway, trained lookouts are used to detect all objects on the surface of the water, including marine mammals.
- Reasonable and prudent actions are implemented to avoid the close interaction of Navy assets and marine mammals.
- While in transit, naval vessels will be alert at all times, use extreme caution, and proceed at a ''safe speed'' so that the vessel can take proper and effective action to avoid a collision with any marine animal and can be stopped within a distance appropriate to the prevailing circumstances and conditions.

Based on the implementation of Navy mitigation measures and the relatively low density of Navy ships in the Study Area, NMFS has concluded preliminarily that the probability of a ship strike is very low, especially for dolphins and porpoises, killer whales, social pelagic odontocetes and pinnipeds that are highly visible, and/or comparatively small and maneuverable. Though more probable, NMFS also believes that the likelihood of a Navy vessel striking a mysticete or sperm whale is low. The Navy did not request take from a ship strike and based on our preliminary determination, NMFS is not recommending that they modify their request at this time. However, NMFS is currently engaged in an internal Section 7 consultation under the ESA and the outcome of that consultation will further inform our final decision.

Mitigation

In order to issue an incidental take authorization (ITA) under Section 101(a)(5)(A) of the MMPA, NMFS must set forth the ''permissible methods of taking pursuant to such activity, and other means of effecting the least practicable adverse impact on such species or stock and its habitat, paying particular attention to rookeries, mating grounds, and areas of similar significance.'' The NDAA of 2004 amended the MMPA as it relates to military-readiness activities and the ITA process such that ''least practicable adverse impact'' shall include consideration of personnel safety, practicality of implementation, and impact on the effectiveness of the ''military readiness activity.'' The training activities described in the NWTRC application are considered military readiness activities.

NMFS reviewed the proposed NWTRC activities and the proposed NWTRC mitigation measures as described in the Navy's LOA application to determine if they would result in the least practicable adverse effect on marine mammals, which includes a careful balancing of the likely benefit of any particular measure to the marine mammals with the likely effect of that measure on personnel safety, practicality of implementation, and impact on the effectiveness of the ''military-readiness activity.'' NMFS determined that further discussion was necessary regarding the use of MFAS/

HFAS for training in the Inshore Area that contains the southern resident killer whale critical habitat.

To address the concerns above, the Navy clarified for NMFS (subsequent to their submittal of the LOA application) that no training utilizing MFAS/HFAS had occurred in the Inshore Area of NWTRC for the last six years, that it is not being conducted now, and that there are no plans to utilize MFAS/HFAS in the Inshore Area. This information has been factored into NMFS' effects analysis.. Because MFAS/HFAS will not be used in this area, there is no reason to authorize take from these activities. However, the Navy indicated that should their plans change in the future they will request authorization under the MMPA. The Navy further explained that no explosive training occurs in the Inshore Area other than the annual detonation of four 2.5lb charges, which are not anticipated to result in the take of marine mammals. Included below are the mitigation measures the Navy proposed (see ''Mitigation Measures Proposed in the Navy's LOA Application'')

Mitigation Measures Proposed in the Navy's LOA Application

This section includes the protective measures proposed by the Navy and is taken directly from their application (with the exception of headings, which have been modified for increased clarity within the context of this proposed rule). In their proposed mitigation, the Navy has included measures to protect sea turtles—those measures are included here as part of the Navy's proposed action. Although measures to protect sea turtles are important, they are not required by the MMPA, and therefore, will not be codified through this regulation or required in any subsequent MMPA LOA. Measures to protect sea turtles will, however, be addressed in the Endangered Species Act section 7 consultation.

General Maritime Measures for All Training at Sea

Personnel Training (for All Training Types)

The use of shipboard lookouts is a critical component of all Navy protective measures. Lookout duties require that they report all objects sighted in the water to the officer of the deck (OOD) (*e.g.,* trash, a periscope, marine mammals, sea turtles) and all disturbances (*e.g.,* surface disturbance, discoloration) that may be indicative of a threat to the vessel and its crew. There are personnel serving as lookouts on station at all times (day and night) when a ship or surfaced submarine is moving through the water.

- All commanding officers (COs), executive officers (XOs), lookouts, officers of the deck (OODs), junior OODs (JOODs), maritime patrol aircraft aircrews, and Anti-submarine Warfare (ASW)/Mine Warfare (MIW) helicopter crews will complete the NMFS-approved Marine Species Awareness Training (MSAT) by viewing the U.S. Navy MSAT digital versatile disk (DVD). All bridge lookouts will complete both parts one and two of the MSAT; part two is optional for other personnel. This training addresses the lookout's role in environmental protection, laws governing the protection of marine species, Navy stewardship commitments and general observation information to aid in avoiding interactions with marine species.
- Navy lookouts will undertake extensive training in order to qualify as a watchstander in accordance with the Lookout Training Handbook (Naval Education and Training Command [NAVEDTRA] 12968–D).
- Lookout training will include on-the-job instruction under the supervision of a qualified, experienced lookout. Following successful completion of this supervised training period, lookouts will complete the Personal Qualification Standard Program, certifying that they have demonstrated the necessary skills (such as detection and reporting of partially submerged objects). Personnel being trained as lookouts can be counted among those listed below as long as supervisors monitor their progress and performance.
- Lookouts will be trained in the most effective means to ensure quick and effective communication within the command structure in order to facilitate implementation of protective measures if marine species are spotted.

Operating Procedures and Collision Avoidance (for All Training Types)

- Prior to major exercises, a Letter of Instruction, Mitigation Measures Message or Environmental Annex to the Operational Order will be issued to further disseminate the personnel training requirement and general marine species protective measures.
- COs will make use of marine species detection cues and information to limit interaction with marine species to the maximum extent possible consistent with safety of the ship.
- While underway, surface vessels will have at least two lookouts with binoculars; surfaced submarines will have at least one lookout with binoculars. Lookouts already posted for safety of navigation and man-overboard precautions may be used to fill this requirement. As part of their regular duties, lookouts will watch for and report to the OOD the presence of marine mammals.
- On surface vessels equipped with a multi-function active sensor, pedestal mounted ''Big Eye'' (20x110) binoculars will be properly installed and in good working order to assist in the detection of marine mammals in the vicinity of the vessel.
- Personnel on lookout will employ visual search procedures employing a scanning methodology in accordance with the Lookout Training Handbook (NAVEDTRA 12968–D).
- After sunset and prior to sunrise, lookouts will employ Night Lookouts Techniques in accordance with the Lookout Training Handbook. (NAVEDTRA 12968–D).
- While in transit, naval vessels will be alert at all times, use extreme caution, and proceed at a ''safe speed'' so that the vessel can take proper and effective action to avoid a collision with any marine animal and can be stopped within a distance appropriate to the prevailing circumstances and conditions.
- When whales have been sighted in the area, Navy vessels will increase vigilance and take reasonable and practicable actions to avoid collisions and activities that might result in close interaction of naval assets and marine mammals. Actions may include changing speed and/or direction and would be dictated by environmental and other conditions (*e.g.,* safety, weather).
- Navy aircraft participating in exercises at sea will conduct and maintain, when operationally feasible and safe, surveillance for marine species of concern as long as it does not violate safety constraints or interfere with the accomplishment of primary operational duties. Marine mammal detections will be immediately reported to assigned Aircraft Control Unit for further dissemination to ships in the vicinity of the marine species as appropriate where it is reasonable to conclude that the course of the ship will likely result in a closing of the distance to the detected marine mammal.

Measures for MFAS Operations

Personnel Training (for MFAS Operations)

- All lookouts onboard platforms involved in ASW training events will review the NMFS-approved Marine Species Awareness Training material prior to use of mid-frequency active sonar.

• All COs, XOs, and officers standing watch on the bridge will have reviewed the Marine Species Awareness Training material prior to a training event employing the use of MFAS/HFAS.

• Navy lookouts will undertake extensive training in order to qualify as a watchstander in accordance with the Lookout Training Handbook (Naval Educational Training [NAVEDTRA], 12968–D).

• Lookout training will include on-the-job instruction under the supervision of a qualified, experienced watchstander. Following successful completion of this supervised training period, lookouts will complete the Personal Qualification Standard program, certifying that they have demonstrated the necessary skills (such as detection and reporting of partially submerged objects). This does not forbid personnel being trained as lookouts from being counted as those listed in previous measures so long as supervisors monitor their progress and performance.

• Lookouts will be trained in the most effective means to ensure quick and effective communication within the command structure in order to facilitate implementation of mitigation measures if marine species are spotted.

Lookout and Watchstander Responsibilities (for MFAS Operations)

• On the bridge of surface ships, there will always be at least three people on watch whose duties include observing the water surface around the vessel.

• All surface ships participating in ASW training events will, in addition to the three personnel on watch noted previously, have at all times during the exercise at least two additional personnel on watch as marine mammal lookouts.

• Personnel on lookout and officers on watch on the bridge will have at least one set of binoculars available for each person to aid in the detection of marine mammals.

• Personnel on lookout will be responsible for reporting all objects or anomalies sighted in the water (regardless of the distance from the vessel) to the Officer of the Deck, since any object or disturbance (*e.g.,* trash, periscope, surface disturbance, discoloration) in the water may be indicative of a threat to the vessel and its crew or indicative of a marine species that may need to be avoided as warranted.

Operating Procedures (for MFAS Operations)

• All personnel engaged in passive acoustic sonar operation (including aircraft, surface ships, or submarines) will monitor for marine mammal vocalizations and report the detection of any marine mammal to the appropriate watch station for dissemination and appropriate action.

• During MFAS operations, personnel will utilize all available sensor and optical systems (such as night vision goggles) to aid in the detection of marine mammals.

• Navy aircraft participating in exercises at sea will conduct and maintain, when operationally feasible and safe, surveillance for marine species of concern as long as it does not violate safety constraints or interfere with the accomplishment of primary operational duties.

• Aircraft with deployed sonobuoys will use only the passive capability of sonobuoys when marine mammals are detected within 200 yds (183 m) of the sonobuoy.

• Marine mammal detections will be immediately reported to assigned Aircraft Control Unit for further dissemination to ships in the vicinity of the marine species as appropriate where it is reasonable to conclude that the course of the ship will likely result in a closing of the distance to the detected marine mammal.

• *Safety Zones*—When marine mammals are detected by any means (aircraft, shipboard lookout, or acoustically) within or closing to inside 1,000 yds (914 m) of the sonar dome (the bow), the ship or submarine will limit active transmission levels to at least 6 decibels (dB) below normal operating levels (a 6-dB reduction equals a 75-percent reduction in power).

■ Ships and submarines will continue to limit maximum transmission levels by this 6-dB factor until the animal has been seen to leave the area, has not been detected for 30 minutes, or the vessel has transited more than 2,000 yds (1829 m) beyond the location of the last detection.

■ Should a marine mammal be detected within or closing to inside 500 yds (457 m) of the sonar dome, active sonar transmissions will be limited to at least 10 dB below the equipment's normal operating level. (A 10-dB reduction equates to a 90-percent power reduction from normal operating levels.) Ships and submarines will continue to limit maximum ping levels by this 10-dB factor until the animal has been seen to leave the area, has not been detected for 30 minutes, or the vessel has transited more than 2,000 yds (1829 m) beyond the location of the last detection.

■ Should the marine mammal be detected within or closing to inside 200 yds (183 m) of the sonar dome, active sonar transmissions will cease. Active sonar will not resume until the animal has been seen to leave the area, has not been detected for 30 minutes, or the vessel has transited more than 2,000 yds (1829 m) beyond the location of the last detection.

■ Special conditions applicable for dolphin and porpoise only: If, after conducting an initial maneuver to avoid close quarters with dolphin or porpoise, the OOD concludes that dolphin or porpoise are deliberately closing to ride the vessel's bow wave, no further mitigation actions would be necessary while the dolphin or porpoise continue to exhibit bow wave riding behavior.

■ If the need for power-down should arise as detailed in ''Safety Zones'' above, the Navy shall follow the requirements as though they were operating at 235 dB—the normal operating level (*i.e.,* the first power-down will be to 229 dB, regardless of at what level above 235 dB active sonar was being operated).

• Prior to start up or restart of active sonar, operators will check that the Safety Zone radius around the sound source is clear of marine mammals.

• *Active sonar levels (generally)*—Navy will operate sonar at the lowest practicable level, not to exceed 235 dB, except as required to meet tactical training objectives.

• Submarine sonar operators will review detection indicators of close-aboard marine mammals prior to the commencement of ASW training events involving MFAS.

Measures for Underwater Detonations

Surface-to-Surface Gunnery (Non-Explosive Rounds)

• A 200-yd (183 m) radius buffer zone will be established around the intended target.

• From the intended firing position, trained lookouts will survey the buffer zone for marine mammals prior to commencement and during the exercise as long as practicable. Due to the distance between the firing position and the buffer zone, lookouts are only expected to visually detect breaching whales, whale blows, and large pods of dolphins and porpoises.

• If applicable, target towing vessels will maintain a lookout. If a marine mammal is sighted in the vicinity of the exercise, the tow vessel will immediately notify the firing vessel in order to secure gunnery firing until the area is clear.

• The exercise will be conducted only when the buffer zone is visible and marine mammals are not detected

within the target area and the buffer zone.

Surface-to-Air Gunnery (Explosive and Non-Explosive Rounds)

- Vessels will orient the geometry of gunnery exercises in order to prevent debris from falling in the area of sighted marine mammals, algal mats, and floating kelp.
- Vessels will expedite the recovery of any parachute deploying aerial targets to reduce the potential for entanglement of marine mammals.
- Target towing aircraft shall maintain a lookout. If a marine mammal is sighted in the vicinity of the exercise, the tow aircraft will immediately notify the firing vessel in order to secure gunnery firing until the area is clear.

Air-to-Surface At-Sea Bombing Exercises (Explosive and Non-Explosive)

- If surface vessels are involved, trained lookouts will survey for floating kelp, which may be inhabited by marine mammals. Ordnance shall not be targeted to impact within 1,000 yds (914 m) of known or observed floating kelp or marine mammals.
- A 1,000 yd (914 m) radius buffer zone will be established around the intended target.
- Aircraft will visually survey the target and buffer zone for marine mammals prior to and during the exercise. The survey of the impact area will be made by flying at 1,500 ft (457 m) or lower, if safe to do so, and at the slowest safe speed. Release of ordnance through cloud cover is prohibited: Aircraft must be able to actually see ordnance impact areas. Survey aircraft should employ most effective search tactics and capabilities.
- The exercise will be conducted only if marine mammals are not visible within the buffer zone.

Air-to-Surface Missile Exercises (Explosive and Non-Explosive)

- Aircraft will visually survey the target area for marine mammals. Visual inspection of the target area will be made by flying at 1,500 (457 m) feet or lower, if safe to do so, and at slowest safe speed. Firing or range clearance aircraft must be able to actually see ordnance impact areas. Explosive ordnance shall not be targeted to impact within 1,800 yds (1646 m) of sighted marine mammals.

Underwater Detonations (Up to 2.5-lb Charges)

Exclusion Zones—All Mine Warfare and Mine Countermeasures Operations involving the use of explosive charges must include exclusion zones for marine mammals to prevent physical and/or acoustic effects to those species. These exclusion zones shall extend in a 700-yard arc (640 yd) radius around the detonation site.

Pre-Exercise Surveys—For Demolition and Ship Mine Countermeasures Operations, pre-exercise surveys shall be conducted within 30 minutes prior to the commencement of the scheduled explosive event. The survey may be conducted from the surface, by divers, and/or from the air, and personnel shall be alert to the presence of any marine mammal. Should such an animal be present within the survey area, the explosive event shall not be started until the animal voluntarily leaves the area. The Navy will ensure the area is clear of marine mammals for a full 30 minutes prior to initiating the explosive event. Personnel will record any marine mammal observations during the exercise as well as measures taken if species are detected within the exclusion zone.

Post-Exercise Surveys—Surveys within the same radius shall also be conducted within 30 minutes after the completion of the explosive event.

Reporting—If there is evidence that a marine mammal may have been stranded, injured or killed by the action, Navy training activities will be suspended immediately and the situation reported immediately by the participating unit to the Officer in Charge of the Exercise (OCE), who will follow Navy procedures for reporting the incident to Commander, Pacific Fleet, Commander, Navy Region Southwest, Environmental Director, and the chain-of-command. The situation will also be reported to NMFS immediately or as soon as clearance procedures allow.

Sinking Exercise

The selection of sites suitable for SINKEXs involves a balance of operational suitability, requirements established under the Marine Protection, Research and Sanctuaries Act (MPRSA) permit granted to the Navy (40 CFR 229.2), and the identification of areas with a low likelihood of encountering ESA-listed species. To meet operational suitability criteria, the locations of SINKEXs must be within a reasonable distance of the target vessels' originating location. The locations should also be close to active military bases to allow participating assets access to shore facilities. For safety purposes, these locations should also be in areas that are not generally used by non-military air or watercraft. The MPRSA permit requires vessels to be sunk in waters which are at least 6000 ft (1829 m) deep and at least 50 nm from land. In general, most listed species prefer areas with strong bathymetric gradients and oceanographic fronts for significant biological activity such as feeding and reproduction. Typical locations include the continental shelf and shelf-edge.

The Navy has developed range clearance procedures to maximize the probability of sighting any ships or marine mammal in the vicinity of an exercise, which are as follows:

- All weapons firing would be conducted during the period 1 hour after official sunrise to 30 minutes before official sunset.
- Extensive range clearance activities would be conducted in the hours prior to commencement of the exercise, ensuring that no shipping is located within the hazard range of the longest-range weapon being fired for that event.
- An exclusion zone with a radius of 1.0 nm (1.9 km) would be established around each target. This exclusion zone is based on calculations using a 990-lb (450-kg) H6 net explosive weight high explosive source detonated 5 ft (1.5 m) below the surface of the water, which yields a distance of 0.85 nm (1.57 km) (cold season) and 0.89 nm (1.65 km) (warm season) beyond which the received level is below the 182 decibels (dB) re: 1 micropascal squared-seconds (μPa2-s) threshold established for the WINSTON S. CHURCHILL (DDG 81) shock trials (U.S. Navy, 2001). An additional buffer of 0.5 nm (0.9 km) would be added to account for errors, target drift, and animal movements. Additionally, a safety zone, which would extend beyond the buffer zone by an additional 0.5 nm (0.9 km), would be surveyed. Together, the zones extend out 2 nm (3.7 km) from the target.
- A series of surveillance overflights shall be conducted prior to the event to ensure that no marine mammals are present in the exclusion zone. Survey protocol will be as follows:
- Overflights within the exclusion zone would be conducted in a manner that optimizes the surface area of the water observed. This may be accomplished through the use of the Navy's Search and Rescue Tactical Aid, which provides the best search altitude, ground speed, and track spacing for the discovery of small, possibly dark objects in the water based on the environmental conditions of the day. These environmental conditions include the angle of sun inclination, amount of daylight, cloud cover, visibility, and sea state.
- All visual surveillance activities would be conducted by Navy personnel

trained in visual surveillance. At least one member of the mitigation team would have completed the Navy's marine mammal training program for lookouts.

• In addition to the overflights, the exclusion zone would be monitored by passive acoustic means, when assets are available. This passive acoustic monitoring would be maintained throughout the exercise. Potential assets include sonobuoys, which can be utilized to detect any vocalizing marine mammals (particularly sperm whales) in the vicinity of the exercise. The sonobuoys would be re-seeded as necessary throughout the exercise. Additionally, passive sonar onboard submarines may be utilized to detect any vocalizing marine mammals in the area. The OCE would be informed of any aural detection of marine mammals and would include this information in the determination of when it is safe to commence the exercise.

• On each day of the exercise, aerial surveillance of the exclusion and safety zones would commence 2 hours prior to the first firing.

• The results of all visual, aerial, and acoustic searches would be reported immediately to the OCE. No weapons launches or firing would commence until the OCE declares the safety and exclusion zones free of marine mammals and threatened and endangered species.

• If a marine mammal observed within the exclusion zone is diving, firing would be delayed until the animal is re-sighted outside the exclusion zone, or 30 minutes have elapsed, whichever occurs first. After 30 minutes, if the animal has not been re-sighted it would be assumed to have left the exclusion zone. The OCE would determine if the marine mammal is in danger of being adversely affected by commencement of the exercise.

• During breaks in the exercise of 30 minutes or more, the exclusion zone would again be surveyed for any marine mammal. If a marine mammal is sighted within the exclusion zone, the OCE would be notified, and the procedure described above would be followed.

• Upon sinking of the vessel, a final surveillance of the exclusion zone would be monitored for 2 hours, or until sunset, to verify that no marine mammals were harmed.

• Aerial surveillance would be conducted using helicopters or other aircraft based on necessity and availability. The Navy has several types of aircraft capable of performing this task; however, not all types are available for every exercise. For each exercise, the available asset best suited for identifying objects on and near the surface of the ocean would be used. These aircraft would be capable of flying at the slow safe speeds necessary to enable viewing of marine vertebrates with unobstructed, or minimally obstructed, downward and outward visibility. The exclusion and safety zone surveys may be cancelled in the event that a mechanical problem, emergency search and rescue, or other similar and unexpected event preempts the use of one of the aircraft onsite for the exercise.

• Every attempt would be made to conduct the exercise in sea states that are ideal for marine mammal sighting—Beaufort Sea State 3 or less. In the event of a sea state of 4 or above, survey efforts would be increased within the zones. This would be accomplished through the use of an additional aircraft, if available, and conducting tight search patterns.

• The exercise would not be conducted unless the exclusion zone could be adequately monitored visually. Should low cloud cover or surface visibility prevent adequate visual monitoring as described previously, the exercise would be delayed until conditions improved, and all of the above monitoring criteria could be met.

• In the unlikely event that any marine mammal is observed to be harmed in the area, a detailed description of the animal would be taken, the location noted, and if possible, photos taken. This information would be provided to NMFS via the Navy's regional environmental coordinator for purposes of identification (*see* the draft Stranding Plan for detail).

• An after action report detailing the exercise's time line, the time the surveys commenced and terminated, amount, and types of all ordnance expended, and the results of survey efforts for each event would be submitted to NMFS.

Explosive Source Sonobuoys Used in EER/IEER (AN/SSQ–110A)

• Crews will conduct visual reconnaissance of the drop area prior to laying their intended sonobuoy pattern. This search should be conducted below 457 m (500 yd) at a slow speed, if operationally feasible and weather conditions permit. In dual aircraft operations, crews are allowed to conduct coordinated area clearances.

• Crews shall conduct a minimum of 30 minutes of visual and aural monitoring of the search area prior to commanding the first post detonation. This 30-minute observation period may include pattern deployment time.

• For any part of the briefed pattern where a post (source/receiver sonobuoy pair) will be deployed within 914 m (1,000 yd) of observed marine mammal activity, deploy the receiver ONLY and monitor while conducting a visual search. When marine mammals are no longer detected within 914 m (1,000 yd) of the intended post position, co-locate the explosive source sonobuoy (AN/SSQ–110A) (source) with the receiver.

• When operationally feasible, crews will conduct continuous visual and aural monitoring of marine mammal activity. This is to include monitoring of own-aircraft sensors from first sensor placement to checking off station and out of RF range of these sensors.

• *Aural Detection*—If the presence of marine mammals is detected aurally, then that should cue the aircrew to increase the diligence of their visual surveillance. Subsequently, if no marine mammals are visually detected, then the crew may continue multi-static active search.

• *Visual Detection*—If marine mammals are visually detected within 914 m (1,000 yd) of the explosive source sonobuoy (AN/SSQ–110A) intended for use, then that payload shall not be detonated. Aircrews may utilize this post once the marine mammals have not been re-sighted for 30 minutes, or are observed to have moved outside the 914 m (1,000 yd) safety buffer, whichever occurs first. Aircrews may shift their multi-static active search to another post, where marine mammals are outside the 914 m (1,000 yd) safety buffer.

• Aircrews shall make every attempt to manually detonate the unexploded charges at each post in the pattern prior to departing the operations area by using the ''Payload 1 Release'' command followed by the ''Payload 2 Release'' command. Aircrews shall refrain from using the ''Scuttle'' command when two payloads remain at a given post. Aircrews will ensure that a 914 m (1,000 yd) safety buffer, visually clear of marine mammals, is maintained around each post as is done during active search operations.

• Aircrews shall only leave posts with unexploded charges in the event of a sonobuoy malfunction, an aircraft system malfunction, or when an aircraft must immediately depart the area due to issues such as fuel constraints, inclement weather, and in-flight emergencies. In these cases, the sonobuoy will self-scuttle using the secondary (detonation occurs by timer approximately 6 hours after water entry) or tertiary (detonation occurs by salt water soluble plug approximately 12 hours after water entry) method.

• Aircrews shall ensure all payloads are accounted for. Explosive source sonobuoys (AN/SSQ–110A) that cannot be scuttled shall be reported as unexploded ordnance via voice communications while airborne, then upon landing via naval message.

• Mammal monitoring shall continue until out of own-aircraft sensor range.

Mitigation Conclusions

NMFS has carefully evaluated the Navy's proposed mitigation measures and considered a broad range of other measures in the context of ensuring that NMFS prescribes the means of effecting the least practicable adverse impact on the affected marine mammal species and stocks and their habitat. Our evaluation of potential measures included consideration of the following factors in relation to one another:

• The manner in which, and the degree to which, the successful implementation of the measure is expected to minimize adverse impacts to marine mammals.

• The proven or likely efficacy of the specific measure to minimize adverse impacts as planned.

• The practicability of the measure for applicant implementation, including consideration of personnel safety, practicality of implementation, and impact on the effectiveness of the military readiness activity.

In some cases, additional mitigation measures are required beyond those that the applicant proposes. Any mitigation measure(s) prescribed by NMFS should be able to accomplish, have a reasonable likelihood of accomplishing (based on current science), or contribute to the accomplishment of one or more of the general goals listed below:

(a) Avoidance or minimization of injury or death of marine mammals wherever possible (goals b, c, and d may contribute to this goal).

(b) A reduction in the numbers of marine mammals (total number or number at biologically important time or location) exposed to received levels of MFAS/HFAS, underwater detonations, or other activities expected to result in the take of marine mammals (this goal may contribute to a, above, or to reducing harassment takes only).

(c) A reduction in the number of times (total number or number at biologically important time or location) individuals would be exposed to received levels of MFAS/HFAS, underwater detonations, or other activities expected to result in the take of marine mammals (this goal may contribute to a, above, or to reducing harassment takes only).

(d) A reduction in the intensity of exposures (either total number or number at biologically important time or location) to received levels of MFAS/HFAS, underwater detonations, or other activities expected to result in the take of marine mammals (this goal may contribute to a, above, or to reducing the severity of harassment takes only).

(e) Avoidance or minimization of adverse effects to marine mammal habitat, paying special attention to the food base, activities that block or limit passage to or from biologically important areas, permanent destruction of habitat, or temporary destruction/disturbance of habitat during a biologically important time.

(f) For monitoring directly related to mitigation—an increase in the probability of detecting marine mammals, thus allowing for more effective implementation of the mitigation (shut-down zone, *etc.*).

Based on our evaluation of the Navy's proposed measures, as well as other measures considered by NMFS or recommended by the public, NMFS has determined preliminarily that the Navy's proposed mitigation measures (especially when the Adaptive Management (*see* Adaptive Management below) component is taken into consideration) are adequate means of effecting the least practicable adverse impacts on marine mammals species or stocks and their habitat, paying particular attention to rookeries, mating grounds, and areas of similar significance, while also considering personnel safety, practicality of implementation, and impact on the effectiveness of the military readiness activity. Further detail is included below.

The proposed rule comment period will afford the public an opportunity to submit recommendations, views and/or concerns regarding this action and the proposed mitigation measures. While NMFS has determined preliminarily that the Navy's proposed mitigation measures will effect the least practicable adverse impact on the affected species or stocks and their habitat, NMFS will consider all public comments to help inform our final decision. Consequently, the proposed mitigation measures may be refined, modified, removed, or added to prior to the issuance of the final rule based on public comments received, and where appropriate, further analysis of any additional mitigation measures.

NMFS believes that the range clearance procedures and shutdown/safety zone/exclusion zone measures the Navy has proposed will enable the Navy to avoid injuring marine mammals and will enable them to minimize the numbers of marine mammals exposed to levels associated with TTS for the following reasons:

MFAS/HFAS

The Navy's standard protective measures indicate that they will ensure powerdown of MFAS/HFAS by 6-dB when a marine mammal is detected within 1,000 yd (914 m), powerdown of 4 more dB (or 10-dB total) when a marine mammal is detected within 500 yd (457 m), and will cease MFAS/HFAS transmissions when a marine mammal is detected within 200 yd (183 m).

PTS/Injury—NMFS believes that the proposed mitigation measures will allow the Navy to avoid exposing marine mammals to received levels of MFAS/HFAS sound that would result in injury for the following reasons:

• The estimated distance from the most powerful source at which cetaceans and all pinnipeds except harbor seals would receive levels at or above the threshold for PTS/injury/Level A Harassment is approximately 10 m (10.9 yd). The PTS threshold for harbor seals is lower, and the associated distance in which a harbor seal would experience PTS is approximately 50 m.

• NMFS believes that the probability that a marine mammal would approach within the above distances of the sonar dome (to the sides or below) without being seen by the watchstanders (who would then activate a shutdown if the animal was within 200 yd (183 m)) is very low, especially considering that animals would likely avoid approaching a source transmitting at that level at that distance.

• The model predicted that one harbor seal would be exposed to levels associated with injury, however, the model does not consider the mitigation or likely avoidance behaviors and NMFS believes that injury is unlikely when those factors are considered.

TTS—NMFS believes that the proposed mitigation measures will allow the Navy to minimize exposure of marine mammals to received levels of MFAS/HFAS sound associated with TTS for the following reasons:

• The estimated maximum distance from the most powerful source at which cetaceans and all pinnipeds except harbor seals would receive levels at or above the threshold for TTS is approximately 140 m from the source in most operating environments (except for harbor seals for which the distance is approximately 400 m).

• Based on the size of the animals, average group size, behavior, and average dive time, NMFS believes that the probability that Navy watchstanders will visually detect mysticetes or sperm whales, dolphins, social pelagic species

(pilot whales, melon-headed whales, *etc.*), and sea lions at some point within the 1,000 yd (914 km) safety zone before they are exposed to the TTS threshold levels is high, which means that the Navy would often be able to shutdown or powerdown to avoid exposing these species to sound levels associated with TTS.

• However, seals and more cryptic (animals that are difficult to detect and observe), deep-diving cetaceans (beaked whales and *Kogia* spp.) are less likely to be visually detected and could potentially be exposed to levels of MFAS/HFAS expected to cause TTS. Animals at depth in one location would not be expected to be continuously exposed to repeated sonar signals given the typical 5–10+ knot speed of Navy surface ships during ASW events. During a typical one-hour subsurface dive by a beaked whale, the ship will have moved over 5 to 10 nm from the original location. Additionally, the Navy's model does not predict TTS exposures of beaked whales or Kogia, although it does predict TTS exposure of 245 harbor seals.

• Additionally, the Navy's bow-riding mitigation exception for dolphins may sometimes result in dolphins being exposed to levels of MFAS/HFAS likely to result in TTS. However, there are combinations of factors that reduce the acoustic energy received by dolphins approaching ships to ride in bow waves. Dolphins riding a ship's bow wave are outside of the main beam of the MFAS vertical beam pattern. Source levels drop quickly outside of the main beam. Sidelobes of the radiate beam pattern that point to the surface are significantly lower in power. Together with spherical spreading losses, received levels in the ship's bow wave can be more than 42 dB less than typical source level (*i.e.*, 235 dB − 42 dB = 193 dB SPL). Finally, bow wave riding dolphins are frequently in and out of a bubble layer generated by the breaking bow waves. This bubble layer is an excellent scatterer of acoustic energy and can further reduce received energy.

Underwater Explosives

The Navy utilizes exclusion zones (wherein explosive detonation will not begin/continue if animals are within the zone) for explosive exercises. Table 3 identifies the various explosives, the estimated distance at which animals will receive levels associated with take (*see* Acoustic Take Criteria Section), and the exclusion zone associated with the explosive types.

Mortality and Injury—NMFS believes that the mitigation measures will allow the Navy to avoid exposing marine mammals to underwater detonations that would result in injury or mortality for the following reasons:

• Surveillance for large charges (which includes aerial and passive acoustic detection methods, when available, to ensure clearance) begins two hours before the exercise and extends to 2 nm (3,704 m) from the source. Surveillance for all charges extends out 2–12 times the farthest distance from the source at which injury would be anticipated to occur (*see* Table 3).

• Animals would need to be less than 120–694 m (131–759 yd) (large explosives) or 21–112 m (23–123 yd) (smaller charges) from the source to be injured.

• Unlike for active sonar, an animal would need to be present at the exact moment of the explosion(s) (except for the short series of gunfire example in GUNEX) to be taken.

• The model predicted that 14 animals would be exposed to levels associated with injury, and 2 animals would be exposed to levels associated with death (though for the reasons explained above, NMFS does not believe they will be exposed to those levels).

• When the implementation of the exclusion zones (*i.e.*, the fact that the Navy will not start a detonation or will not continue to detonate explosives if an animal is detected within the exclusion zone) is considered in combination with the factors described in the above bullets, NMFS believes that the Navy's mitigation will prevent injury and mortality to marine mammals from explosives.

TTS—NMFS believes that the proposed mitigation measures will allow the Navy to minimize the exposure of marine mammals to underwater detonations that would result in TTS for the following reasons:

• About 200 animals annually were predicted to be exposed to explosive levels that would result in TTS. For the reasons explained above, NMFS believes that most modeled TTS takes can be avoided, especially dolphins, mysticetes and sperm whales, and social pelagic species.

• However, pinnipeds and more cryptic, deep-diving species (beaked whales and *Kogia* spp.) are less likely to be visually detected and could potentially be exposed to explosive levels expected to cause TTS. The model estimated that one beaked whale, zero Kogia, 44 northern fur seal, 29 northern elephant seal, 2 harbor seal, 1 California sea lion, and 3 Steller sea lions would be exposed to TTS levels.

• Additionally, for two of the exercise types (SINKEX and BOMBEX), the distance at which an animal would be expected to receive sound or pressure levels associated with TTS (182 dB SEL or 23 psi) is sometimes larger than the exclusion zone, which means that for those two exercise types, some individuals will likely be exposed to levels associated with TTS outside of the exclusion zone.

Research

The Navy provides a significant amount of funding and support to marine research. In the past five years the agency funded over $100 million ($26 million in FY08 alone) to universities, research institutions, Federal laboratories, private companies, and independent researchers around the world to study marine mammals. The U.S. Navy sponsors 70% of all U.S. research concerning the effects of human-generated sound on marine mammals and 50% of such research conducted worldwide. Major topics of Navy-supported research include the following:

• Better understanding of marine species distribution and important habitat areas,

• Developing methods to detect and monitor marine species before and during training,

• Understanding the effects of sound on marine mammals, sea turtles, fish, and birds, and

• Developing tools to model and estimate potential effects of sound.

This research is directly applicable to Fleet training activities, particularly with respect to the investigations of the potential effects of underwater noise sources on marine mammals and other protected species. Proposed training activities employ active sonar and underwater explosives, which introduce sound into the marine environment.

The Marine Life Sciences Division of the Office of Naval Research currently coordinates six programs that examine the marine environment and are devoted solely to studying the effects of noise and/or the implementation of technology tools that will assist the Navy in studying and tracking marine mammals. The six programs are as follows:

• Environmental Consequences of Underwater Sound,

• Non-Auditory Biological Effects of Sound on Marine Mammals,

• Effects of Sound on the Marine Environment,

• Sensors and Models for Marine Environmental Monitoring,

• Effects of Sound on Hearing of Marine Animals, and

• Passive Acoustic Detection, Classification, and Tracking of Marine Mammals.

The Navy has also developed the technical reports referenced within this document, which include the Marine Resource Assessments and the Navy OPAREA Density Estimates (NODE) reports. Furthermore, research cruises by the National Marine Fisheries Service (NMFS) and by academic institutions have received funding from the U.S. Navy.

The Navy has sponsored several workshops to evaluate the current state of knowledge and potential for future acoustic monitoring of marine mammals. The workshops brought together acoustic experts and marine biologists from the Navy and other research organizations to present data and information on current acoustic monitoring research efforts and to evaluate the potential for incorporating similar technology and methods on instrumented ranges. However, acoustic detection, identification, localization, and tracking of individual animals still requires a significant amount of research effort to be considered a reliable method for marine mammal monitoring. The Navy supports research efforts on acoustic monitoring and will continue to investigate the feasibility of passive acoustics as a potential mitigation and monitoring tool.

Overall, the Navy will continue to fund ongoing marine mammal research, and is planning to coordinate long term monitoring/studies of marine mammals on various established ranges and operating areas. The Navy will continue to research and contribute to university/external research to improve the state of the science regarding marine species biology and acoustic effects. These efforts include mitigation and monitoring programs; data sharing with NMFS and via the literature for research and development efforts; and future research as described previously.

Memorandum of Agreement (MOA) for Navy Assistance With Stranding Investigations

The Navy and NMFS are currently developing a nationwide MOA (or other mechanism consistent with Federal fiscal law requirements (and all other applicable laws)), that will establish a framework whereby the Navy can (and NMFS will provide examples of how best to) assist NMFS with stranding investigations in certain circumstances.

Long-Term Prospective Study

Apart from this proposed rule, NMFS, with input and assistance from the Navy and several other agencies and entities, will perform a longitudinal observational study of marine mammal strandings to systematically observe for and record the types of pathologies and diseases and investigate the relationship with potential causal factors (*e.g.*, active sonar, seismic, weather). The study will not be a true ''cohort'' study, because we will be unable to quantify or estimate specific active sonar or other sound exposures for individual animals that strand. However, a cross-sectional or correlational analyses, a method of descriptive rather than analytical epidemiology, can be conducted to compare population characteristics, *e.g.*, frequency of strandings and types of specific pathologies between general periods of various anthropogenic activities and non-activities within a prescribed geographic space. In the long-term study, we will more fully and consistently collect and analyze data on the demographics of strandings in specific locations and consider anthropogenic activities and physical, chemical, and biological environmental parameters. This approach in conjunction with true cohort studies (tagging animals, measuring received sounds, and evaluating behavior or injuries) in the presence of activities and non-activities will provide critical information needed to further define the impacts of MTEs and other anthropogenic and non-anthropogenic stressors. In coordination with the Navy and other Federal and non-Federal partners, the comparative study will be designed and conducted for specific sites during intervals of the presence of anthropogenic activities such as active sonar transmission or other sound exposures and absence to evaluate demographics of morbidity and mortality, lesions found, and cause of death or stranding. Additional data that will be collected and analyzed in an effort to control potential confounding factors include variables such as average sea temperature (or just season), meteorological or other environmental variables (*e.g.*, seismic activity), fishing activities, etc. All efforts will be made to include appropriate controls (*i.e.*, no active sonar or no seismic); environmental variables may complicate the interpretation of ''control'' measurements. The Navy and NMFS along with other partners are evaluating mechanisms for funding this study.

Monitoring

In order to issue an ITA for an activity, Section 101(a)(5)(A) of the MMPA states that NMFS must set forth ''requirements pertaining to the monitoring and reporting of such taking''. The MMPA implementing regulations at 50 CFR 216.104(a)(13) indicate that requests for LOAs must include the suggested means of accomplishing the necessary monitoring and reporting that will result in increased knowledge of the species and of the level of taking or impacts on populations of marine mammals that are expected to be present.

Monitoring measures prescribed by NMFS should accomplish one or more of the following general goals:

(a) An increase in our understanding of how many marine mammals are likely to be exposed to levels of MFAS/HFAS (or explosives or other stimuli) that we associate with specific adverse effects, such as behavioral harassment, TTS, or PTS.

(b) An increase in our understanding of how individual marine mammals respond (behaviorally or physiologically) to MFAS/HFAS (at specific received levels), explosives, or other stimuli expected to result in take.

(c) An increase in our understanding of how anticipated takes of individuals (in different ways and to varying degrees) may impact the population, species, or stock (specifically through effects on annual rates of recruitment or survival).

(d) An increased knowledge of the affected species.

(e) An increase in our understanding of the effectiveness of certain mitigation and monitoring measures.

(f) A better understanding and record of the manner in which the authorized entity complies with the incidental take authorization.

(g) An increase in the probability of detecting marine mammals, both within the safety zone (thus allowing for more effective implementation of the mitigation) and in general to better achieve the above goals.

Proposed Monitoring Plan for the NWTRC

The Navy has submitted a draft Monitoring Plan for the NWTRC which may be viewed at NMFS' Web site: *http://www.nmfs.noaa.gov/pr/permits/incidental.htm#applications*. NMFS and the Navy have worked together on the development of this plan in the months preceding the publication of this proposed rule; however, we are still refining the plan and anticipate that it will contain more details by the time NMFS issues the final rule. Additionally, the plan may be modified or supplemented based on comments or new information received from the public during the public comment period. A summary of the primary components of the plan follows.

The draft Monitoring Plan for NWTRC has been designed as a collection of focused ''studies'' (described fully in the NWTRC draft Monitoring Plan) to gather data that will allow the Navy to address the following questions:

(a) Are marine mammals exposed to MFAS/HFAS, especially at levels associated with adverse effects (*i.e.*, based on NMFS' criteria for behavioral harassment, TTS, or PTS)? If so, at what levels are they exposed?

(b) If marine mammals are exposed to MFAS/HFAS in the NWTRC Range Complex, do they redistribute geographically as a result of continued exposure? If so, how long does the redistribution last?

(c) If marine mammals are exposed to MFAS/HFAS, what are their behavioral responses to various levels?

(d) What are the behavioral responses of marine mammals and that are exposed to explosives at specific levels?

(e) Is the Navy's suite of mitigation measures for MFAS/HFAS (*e.g.*, measures agreed to by the Navy through permitting) effective at preventing TTS, injury, and mortality of marine mammals?

Data gathered in these studies will be collected by qualified, professional marine mammal biologists that are experts in their field. They will use a combination of the following methods to collect data:

- Contracted vessel and aerial surveys.
- Passive acoustics.
- Marine mammal observers on Navy ships.
- Tagging (satellite and acoustic).

In the three proposed study designs (all of which cover multiple years), the above methods will be used separately or in combination to monitor marine mammals in different combinations before, during, and after training activities utilizing MFAS/HFAS.

This monitoring plan has been designed to gather data on all species of marine mammals that are observed in the NWTRC, however, where appropriate priority will be given to beaked whales, ESA-listed species, killer whales, and harbor porpoises. The Plan recognizes that deep-diving and cryptic species of marine mammals such as beaked whales have a low probability of detection (Barlow and Gisiner, 2006). Therefore, methods will be utilized to attempt to address this issue (*e.g.*, passive acoustic monitoring).

In addition to the Monitoring Plan for NWTRC, by the end of 2009, the Navy will have completed an Integrated Comprehensive Monitoring Program (ICMP) Plan. The ICMP will provide the overarching structure and coordination that will, over time, compile data from both range specific monitoring plans (such as AFAST, the Hawaii Range Complex, and the Southern California Range Complex) as well as Navy funded research and development (R&D) studies. The primary objectives of the ICMP are to:

- Monitor Navy training events, particularly those involving MFAS and underwater detonations, for compliance with the terms and conditions of ESA Section 7 consultations or MMPA authorizations;
- Collect data to support estimating the number of individuals exposed to sound levels above current acoustic thresholds;
- Assess the efficacy of the Navy's current marine species mitigation;
- Add to the knowledge base on potential behavioral and physiological effects to marine species from mid-frequency active sonar and underwater detonations; and,
- Assess the practicality and effectiveness of a number of mitigation tools and techniques (some not yet in use).

More information about the ICMP may be found in the draft Monitoring Plan for NWTRC.

Monitoring Workshop

The Navy, with guidance and support from NMFS, will convene a Monitoring Workshop, including marine mammal and acoustic experts as well as other interested parties, in 2011. The Monitoring Workshop participants will review the monitoring results from the previous two years of monitoring pursuant to the NWTRC rule as well as monitoring results from other Navy rules and LOAs (*e.g.*, the Southern California Range Complex (SOCAL), Hawaii Range Complex (HRC), *etc.*). The Monitoring Workshop participants would provide their individual recommendations to the Navy and NMFS on the monitoring plan(s) after also considering the current science (including Navy research and development) and working within the framework of available resources and feasibility of implementation. NMFS and the Navy would then analyze the input from the Monitoring Workshop participants and determine the best way forward from a national perspective. Subsequent to the Monitoring Workshop, modifications would be applied to monitoring plans as appropriate.

Adaptive Management

The final regulations governing the take of marine mammals incidental to Navy training exercises in the NWTRC will contain an adaptive management component. Our understanding of the effects of MFAS/HFAS and explosives on marine mammals is still in its relative infancy, and yet the science in this field is evolving fairly quickly. These circumstances make the inclusion of an adaptive management component both valuable and necessary within the context of 5-year regulations for activities that have been associated with marine mammal mortality in certain circumstances and locations (though not the NWTRC in the Navy's over 60 years of use of the area for testing and training). The use of adaptive management will allow NMFS to consider new data from different sources to determine (in coordination with the Navy) on an annual basis if mitigation or monitoring measures should be modified or added (or deleted) if new data suggests that such modifications are appropriate (or are not appropriate) for subsequent annual LOAs.

Following are some of the possible sources of applicable data:

■ Results from the Navy's monitoring from the previous year (either from NWTRC or other locations).

■ Findings of the Workshop that the Navy will convene in 2011 to analyze monitoring results to date, review current science, and recommend modifications, as appropriate to the monitoring protocols to increase monitoring effectiveness.

■ Compiled results of Navy funded research and development (R&D) studies (presented pursuant to the ICMP, which is discussed elsewhere in this document).

■ Results from specific stranding investigations (either from NWTRC or other locations, and involving coincident MFAS/HFAS of explosives training or not involving coincident use).

■ Results from the Long Term Prospective Study described above.

■ Results from general marine mammal and sound research (funded by the Navy (described above) or otherwise).

■ Any information which reveals that marine mammals may have been taken in a manner, extent or number not authorized by these regulations or subsequent Letters of Authorization.

Mitigation measures could be modified or added (or deleted) if new data suggests that such modifications would have (or do not have) a reasonable likelihood of accomplishing the goals of mitigation laid out in this proposed rule and if the measures are practicable. NMFS would also coordinate with the Navy to modify or

add to (or delete) the existing monitoring requirements if the new data suggest that the addition of (or deletion of) a particular measure would more effectively accomplish the goals of monitoring laid out in this proposed rule. The reporting requirements associated with this proposed rule are designed to provide NMFS with monitoring data from the previous year to allow NMFS to consider the data and issue annual LOAs. NMFS and the Navy will meet annually, prior to LOA issuance, to discuss the monitoring reports, Navy R&D developments, and current science and whether mitigation or monitoring modifications are appropriate.

Reporting

In order to issue an ITA for an activity, Section 101(a)(5)(A) of the MMPA states that NMFS must set forth ''requirements pertaining to the monitoring and reporting of such taking''. Effective reporting is critical both to compliance as well as ensuring that the most value is obtained from the required monitoring. Some of the reporting requirements are still in development and the final rule may contain additional details not contained in the proposed rule. Additionally, proposed reporting requirements may be modified, removed, or added based on information or comments received during the public comment period. Currently, there are several different reporting requirements pursuant to these proposed regulations:

General Notification of Injured or Dead Marine Mammals

Navy personnel will ensure that NMFS is notified immediately ((*see* Communication Plan) or as soon as clearance procedures allow) if an injured, stranded, or dead marine mammal is found during or shortly after, and in the vicinity of, any Navy training exercise utilizing MFAS, HFAS, or underwater explosive detonations. The Navy will provide NMFS with species or description of the animal(s), the condition of the animal(s) (including carcass condition if the animal is dead), location, time of first discovery, observed behaviors (if alive), and photo or video (if available).

In the event that an injured, stranded, or dead marine mammal is found by the Navy that is not in the vicinity of, or during or shortly after MFAS, HFAS, or underwater explosive detonations, the Navy will report the same information as listed above as soon as operationally feasible and clearance procedures allow.

General Notification of a Ship Strike

In the event of a ship strike by any Navy vessel, at any time or place, the Navy shall do the following:

- Immediately report to NMFS the species identification (if known), location (lat/long) of the animal (or the strike if the animal has disappeared), and whether the animal is alive or dead (or unknown).
- Report to NMFS as soon as operationally feasible the size and length of animal, an estimate of the injury status (ex., dead, injured but alive, injured and moving, unknown, *etc.*), vessel class/type and operational status.
- Report to NMFS the vessel length, speed, and heading as soon as feasible.
- Provide NMFS a photo or video, if equipment is available.

Event Communication Plan

The Navy shall develop a communication plan that will include all of the communication protocols (phone trees, *etc.*) and associated contact information required for NMFS and the Navy to carry out the necessary expeditious communication required in the event of a stranding or ship strike, including as described in the proposed notification measures above.

Annual NWTRC Report

The Navy will submit an Annual NWTRC Report on October 1 of every year (covering data gathered through August 1). This report shall contain the subsections and information indicated below.

ASW Summary

This section shall include the following information as summarized from non-major training exercises (unit-level exercises, such as TRACKEXs and MIW):

(a) *Total Hours*—Total annual hours of each type of sonar source (along with explanation of how hours are calculated for sources typically quantified in alternate way (buoys, torpedoes, etc.))

(b) *Cumulative Impacts*—To the extent practicable, the Navy, in coordination with NMFS, shall develop and implement a method of annually reporting non-major training (*i.e.*, ULT) utilizing hull-mounted sonar. The report shall present an annual (and seasonal, where practicable) depiction of non-major training exercises geographically across NWTRC. The Navy shall include (in the NWTRC annual report) a brief annual progress update on the status of the development of an effective and unclassified method to report this information until an agreed-upon (with NMFS) method has been developed and implemented.

Sinking Exercises (SINKEXs)

This section shall include the following information for each SINKEX completed that year:

(a) *Exercise info:*

(i) Location.

(ii) Date and time exercise began and ended.

(iii) Total hours of observation by watchstanders before, during, and after exercise.

(iv) Total number and types of rounds expended/explosives detonated.

(v) Number and types of passive acoustic sources used in exercise.

(vi) Total hours of passive acoustic search time.

(vii) Number and types of vessels, aircraft, *etc.*, participating in exercise.

(viii) Wave height in feet (high, low and average during exercise).

(ix) Narrative description of sensors and platforms utilized for marine mammal detection and timeline illustrating how marine mammal detection was conducted.

(b) Individual marine mammal observation during SINKEX (by Navy lookouts) info:

(i) Location of sighting.

(ii) Species (if not possible—indication of whale/dolphin/pinniped).

(iii) Number of individuals.

(iv) Calves observed (y/n).

(v) Initial detection sensor.

(vi) Length of time observers maintained visual contact with marine mammal.

(vii) Wave height.

(viii) Visibility.

(ix) Whether sighting was before, during, or after detonations/exercise, and how many minutes before or after.

(x) Distance of marine mammal from actual detonations (or target spot if not yet detonated)—use four categories to define distance: (1) The modeled injury threshold radius for the largest explosive used in that exercise type in that OPAREA (694 m for SINKEX in NWTRC); (2) the required exclusion zone (1 nm for SINKEX in NWTRC); (3) the required observation distance (if different than the exclusion zone (2 nm for SINKEX in NWTRC); and (4) greater than the required observed distance. For example, in this case, the observer would indicate if < m, from 694 m–1 nm, from 1 nm–2 nm, and > 2 nm.

(xi) *Observed behavior*—Watchstanders will report, in plain language and without trying to categorize in any way, the observed behavior of the animals (such as animal closing to bow ride, paralleling course/speed, floating on surface and not

swimming *etc.*), including speed and direction.

(xii) *Resulting mitigation implementation*—Indicate whether explosive detonations were delayed, ceased, modified, or not modified due to marine mammal presence and for how long.

(xiii) If observation occurs while explosives are detonating in the water, indicate munitions type in use at time of marine mammal detection.

Improved Extended Echo-Ranging System (IEER) Summary

This section shall include an annual summary of the following IEER information:

(a) Total number of IEER events conducted in NWTRC.

(b) Total expended/detonated rounds (buoys).

(c) Total number of self-scuttled IEER rounds.

Explosives Summary

The Navy is in the process of improving the methods used to track explosive use to provide increased granularity. To the extent practicable, the Navy will provide the information described below for all of their explosive exercises. Until the Navy is able to report in full the information below, they will provide an annual update on the Navy's explosive tracking methods, including improvements from the previous year.

(a) Total annual number of each type of explosive exercise (of those identified as part of the ''specified activity'' in this final rule) conducted in NWTRC.

(b) Total annual expended/detonated rounds (missiles, bombs, *etc.*) for each explosive type.

NWTRC 5-Yr Comprehensive Report

The Navy shall submit to NMFS a draft report that analyzes and summarizes all of the multi-year marine mammal information gathered during ASW and explosive exercises for which annual reports are required (Annual NWTRC Exercise Reports and NWTRC Monitoring Plan Reports). This report will be submitted at the end of the fourth year of the rule (November 2013), covering activities that have occurred through June 1, 2013.

Comprehensive National ASW Report

By June, 2014, the Navy shall submit a draft National Report that analyzes, compares, and summarizes the active sonar data gathered (through January 1, 2014) from the watchstanders and pursuant to the implementation of the Monitoring Plans for the Northwest Training Range Complex, the Southern California Range Complex, the Atlantic Fleet Active Sonar Training, the Hawaii Range Complex, the Marianas Islands Range Complex, and the Gulf of Alaska.

Estimated Take of Marine Mammals

As mentioned previously, one of the main purposes of NMFS' effects assessments is to identify the permissible methods of taking, meaning: The nature of the take (*e.g.*, resulting from anthropogenic noise vs. from ship strike, *etc.*); the regulatory level of take (*i.e.*, mortality vs. Level A or Level B harassment) and the amount of take. In the Potential Effects of Exposure of Marine Mammal to MFAS/HFAS and Underwater Detonations section, NMFS identified the lethal responses, physical trauma, sensory impairment (permanent and temporary threshold shifts and acoustic masking), physiological responses (particular stress responses), and behavioral responses that could potentially result from exposure to MFAS/HFAS or underwater explosive detonations. In this section, we will relate the potential effects to marine mammals from MFAS/HFAS and underwater detonation of explosives to the MMPA statutory definitions of Level A and Level B Harassment and attempt to quantify the effects that might occur from the specific training activities that the Navy is proposing in the NWTRC.

As mentioned previously, behavioral responses are context-dependent, complex, and influenced to varying degrees by a number of factors other than just received level. For example, an animal may respond differently to a sound emanating from a ship that is moving towards the animal than it would to an identical received level coming from a vessel that is moving away, or to a ship traveling at a different speed or at a different distance from the animal. At greater distances, though, the nature of vessel movements could also potentially not have any effect on the animal's response to the sound. In any case, a full description of the suite of factors that elicited a behavioral response would sometimes include a mention of the vicinity, speed and movement of the vessel, or other factors. So, while sound sources and the received levels are the primary focus of the analysis and those that are laid out quantitatively in the regulatory text, it is with the understanding that other factors related to the training are sometimes contributing to the behavioral responses of marine mammals, although they cannot be quantified.

Definition of Harassment

As mentioned previously, with respect to military readiness activities, Section 3(18)(B) of the MMPA defines ''harassment'' as: (i) Any act that injures or has the significant potential to injure a marine mammal or marine mammal stock in the wild [Level A Harassment]; or (ii) any act that disturbs or is likely to disturb a marine mammal or marine mammal stock in the wild by causing disruption of natural behavioral patterns, including, but not limited to, migration, surfacing, nursing, breeding, feeding, or sheltering, to a point where such behavioral patterns are abandoned or significantly altered [Level B Harassment].

Level B Harassment

Of the potential effects that were described in the Potential Effects of Exposure of Marine Mammal to MFAS/HFAS and Underwater Detonations Section, the following are the types of effects that fall into the Level B Harassment category:

Behavioral Harassment—Behavioral disturbance that rises to the level described in the definition above, when resulting from exposures to MFAS/HFAS or underwater detonations (or another stressor), is considered Level B Harassment. Louder sounds (when other factors are not considered) are generally expected to elicit a stronger response. Some of the lower level physiological stress responses discussed in the Potential Effects of Exposure of Marine Mammal to MFAS/HFAS and Underwater Detonations Section: Stress Section will also likely co-occur with the predicted harassments, although these responses are more difficult to detect and fewer data exist relating these responses to specific received levels of sound. When Level B Harassment is predicted based on estimated behavioral responses, those takes may have a stress-related physiological component as well.

In the effects section above, we described the Southall *et al.*, (2007) severity scaling system and listed some examples of the three broad categories of behaviors: (0–3: Minor and/or brief behaviors); 4–6 (Behaviors with higher potential to affect foraging, reproduction, or survival); 7–9 (Behaviors considered likely to affect the aforementioned vital rates). Generally speaking, MMPA Level B Harassment, as defined in this document, would include the behaviors described in the 7–9 category, and a subset, dependent on context and other considerations, of the behaviors described in the 4–6 categories.

Behavioral harassment would not typically include behaviors ranked 0–3 in Southall *et al.* (2007).

Acoustic Masking and Communication Impairment—The severity or importance of an acoustic masking event can vary based on the length of time that the masking occurs, the frequency of the masking signal (which determines which sounds that are masked, which may be of varying importance to the animal), and other factors. Some acoustic masking would be considered Level B Harassment, if it can disrupt natural behavioral patterns by interrupting or limiting the marine mammal's receipt or transmittal of important information or environmental cues.

TTS—As discussed previously, TTS can disrupt behavioral patterns by inhibiting an animal's ability to communicate with conspecifics and interpret other environmental cues important for predator avoidance and prey capture. However, depending on the degree (elevation of threshold in dB), duration (*i.e.*, recovery time), and frequency range of TTS, and the context in which it is experienced, TTS can have effects on marine mammals ranging from discountable to serious (similar to those discussed in auditory masking). For example, a marine mammal may be able to readily compensate for a brief, relatively small amount of TTS in a non-critical frequency range that takes place during a time when the animal is traveling through the open ocean, where ambient noise is lower and there are not as many competing sounds present. Alternatively, a larger amount and longer duration of TTS sustained during a time when communication is critical for successful mother/calf interactions could have more serious impacts if it were in the same frequency band as the necessary vocalizations and of a severity that it impeded communication.

The following physiological mechanisms are thought to play a role in inducing auditory fatigue: Effects to sensory hair cells in the inner ear that reduce their sensitivity, modification of the chemical environment within the sensory cells, residual muscular activity in the middle ear, displacement of certain inner ear membranes, increased blood flow, and post-stimulatory reduction in both efferent and sensory neural output. Ward (1997) suggested that when these effects result in TTS rather than PTS, they are within the normal bounds of physiological variability and tolerance and do not represent a physical injury. Additionally, Southall *et al.*, (2007) indicate that although PTS is a tissue injury, TTS is not, because the reduced hearing sensitivity following exposure to intense sound results primarily from fatigue, not loss, of cochlear hair cells and supporting structures and is reversible. Accordingly, NMFS classifies TTS (when resulting from exposure to either MFAS/HFAS or underwater detonations) as Level B Harassment, not Level A Harassment (injury).

Level A Harassment

Of the potential effects that were described in the Potential Effects of Exposure of Marine Mammals to MFAS/HFAS and Underwater Detonations Section, following are the types of effects that fall into the Level A Harassment category:

PTS—PTS (resulting either from exposure to MFAS/HFAS or explosive detonations) is irreversible and considered an injury. PTS results from exposure to intense sounds that cause a permanent loss of inner or outer cochlear hair cells or exceed the elastic limits of certain tissues and membranes in the middle and inner ears and result in changes in the chemical composition of the inner ear fluids. Although PTS is considered an injury, the effects of PTS on the fitness of an individual can vary based on the degree of TTS and the frequency band that it is in.

Tissue Damage due to Acoustically Mediated Bubble Growth—A few theories suggest ways in which gas bubbles become enlarged through exposure to intense sounds (MFAS/HFAS) to the point where tissue damage results. In rectified diffusion, exposure to a sound field would cause bubbles to increase in size. A short duration of active sonar pings (such as that which an animal exposed to MFAS would be most likely to encounter) would not likely be long enough to drive bubble growth to any substantial size. Alternately, bubbles could be destabilized by high-level sound exposures such that bubble growth then occurs through static diffusion of gas out of the tissues. The degree of supersaturation and exposure levels observed to cause microbubble destabilization are unlikely to occur, either alone or in concert because of how close an animal would need to be to the sound source to be exposed to high enough levels, especially considering the likely avoidance of the sound source and the required mitigation. Still, possible tissue damage from either of these processes would be considered an injury.

Tissue Damage due to Behaviorally Mediated Bubble Growth—Several authors suggest mechanisms in which marine mammals could behaviorally respond to exposure to MFAS/HFAS by altering their dive patterns in a manner (unusually rapid ascent, unusually long series of surface dives, *etc.*) that might result in unusual bubble formation or growth ultimately resulting in tissue damage (emboli, *etc.*). In this scenario, the rate of ascent would need to be sufficiently rapid to compromise behavioral or physiological protections against nitrogen bubble formation. There is considerable disagreement among scientists as to the likelihood of this phenomenon (Piantadosi and Thalmann, 2004; Evans and Miller, 2003). Although it has been argued that the tissue effects observed from recent beaked whale strandings are consistent with gas emboli and bubble-induced tissue separations (Jepson *et al.*, 2003; Fernandez *et al.*, 2005), nitrogen bubble formation as the cause of the traumas has not been verified. If tissue damage does occur by this phenomenon, it would be considered an injury.

Physical Disruption of Tissues Resulting from Explosive Shock Wave—Physical damage of tissues resulting from a shock wave (from an explosive detonation) is classified as an injury. Blast effects are greatest at the gas-liquid interface (Landsberg, 2000) and gas-containing organs, particularly the lungs and gastrointestinal tract, are especially susceptible (Goertner, 1982; Hill 1978; Yelverton *et al.*, 1973). Nasal sacs, larynx, pharynx, trachea, and lungs may be damaged by compression/expansion caused by the oscillations of the blast gas bubble (Reidenberg and Laitman, 2003). Severe damage (from the shock wave) to the ears can include tympanic membrane rupture, fracture of the ossicles, damage to the cochlea, hemorrhage, and cerebrospinal fluid leakage into the middle ear.

Vessel Strike, Ordnance Strike, Entanglement—Although not anticipated (or authorized) to occur, vessel strike, ordnance strike, or entanglement in materials associated with the specified action are considered Level A Harassment or mortality.

Acoustic Take Criteria

For the purposes of an MMPA incidental take authorization, three types of take are identified: Level B Harassment; Level A Harassment; and mortality (or serious injury leading to mortality). The categories of marine mammal responses (physiological and behavioral) that fall into the two harassment categories were described in the previous section.

Because the physiological and behavioral responses of the majority of the marine mammals exposed to MFAS/HFAS and underwater detonations

cannot be detected or measured (not all responses visible external to animal, portion of exposed animals underwater (so not visible), many animals located many miles from observers and covering very large area, *etc.*) and because NMFS must authorize take prior to the impacts to marine mammals, a method is needed to estimate the number of individuals that will be taken, pursuant to the MMPA, based on the proposed action. To this end, NMFS developed acoustic criteria that estimate at what received level (when exposed to MFAS/HFAS or explosive detonations) Level B Harassment, Level A Harassment, and mortality (for explosives) of marine mammals would occur. The acoustic criteria for MFAS/HFAS and Underwater Detonations (IEER) are discussed below.

MFAS/HFAS Acoustic Criteria

Because relatively few applicable data exist to support acoustic criteria specifically for HFAS and because such a small percentage of the active sonar pings that marine mammals will likely be exposed to incidental to this activity come from a HFAS source (the vast majority come from MFAS sources), NMFS will apply the criteria developed for the MFAS to the HFAS as well.

NMFS utilizes three acoustic criteria for MFAS/HFAS: PTS (injury—Level A Harassment), TTS (Level B Harassment), and behavioral harassment (Level B Harassment). Because the TTS and PTS criteria are derived similarly and the PTS criteria was extrapolated from the TTS data, the TTS and PTS acoustic criteria will be presented first, before the behavioral criteria.

For more information regarding these criteria, please see the Navy's DEIS for NWTRC.

Level B Harassment Threshold (TTS)

As mentioned above, behavioral disturbance, acoustic masking, and TTS are all considered Level B Harassment. Marine mammals would usually be behaviorally disturbed at lower received levels than those at which they would likely sustain TTS, so the levels at which behavioral disturbance are likely to occur is considered the onset of Level B Harassment. The behavioral responses of marine mammals to sound are variable, context specific, and, therefore, difficult to quantify (*see* Risk Function section, below). Alternately, TTS is a physiological effect that has been studied and quantified in laboratory conditions. Because data exist to support an estimate of at what received levels marine mammals will incur TTS, NMFS uses an acoustic criteria to estimate the number of marine mammals that might sustain TTS. TTS is a subset of Level B Harassment (along with sub-TTS behavioral harassment) and we are not specifically required to estimate those numbers; however, the more specifically we can estimate the affected marine mammal responses, the better the analysis.

A number of investigators have measured TTS in marine mammals. These studies measured hearing thresholds in trained marine mammals before and after exposure to intense sounds. The existing cetacean TTS data are summarized in the following bullets.

- Schlundt *et al.*, (2000) reported the results of TTS experiments conducted with 5 bottlenose dolphins and 2 belugas exposed to 1-second tones. This paper also includes a reanalysis of preliminary TTS data released in a technical report by Ridgway *et al.*, (1997). At frequencies of 3, 10, and 20 kHz, sound pressure levels (SPLs) necessary to induce measurable amounts (6 dB or more) of TTS were between 192 and 201 dB re 1 μPa (EL = 192 to 201 dB re 1 μPa^2-s). The mean exposure SPL and EL for onset-TTS were 195 dB re 1 μPa and 195 dB re 1 μPa^2-s, respectively.
- Finneran *et al.*, (2001, 2003, 2005) described TTS experiments conducted with bottlenose dolphins exposed to 3-kHz tones with durations of 1, 2, 4, and 8 seconds. Small amounts of TTS (3 to 6 dB) were observed in one dolphin after exposure to ELs between 190 and 204 dB re 1 μ^2-s. These results were consistent with the data of Schlundt *et al.*, (2000) and showed that the Schlundt *et al.*, (2000) data were not significantly affected by the masking sound used. These results also confirmed that, for tones with different durations, the amount of TTS is best correlated with the exposure EL rather than the exposure SPL.
- Nachtigall *et al.*, (2003) measured TTS in a bottlenose dolphin exposed to octave-band sound centered at 7.5 kHz. Nachtigall *et al.*, (2003a) reported TTSs of about 11 dB measured 10 to 15 minutes after exposure to 30 to 50 minutes of sound with SPL 179 dB re 1 μPa (EL about 213 dB re μ^2-s). No TTS was observed after exposure to the same sound at 165 and 171 dB re 1 μPa. Nachtigall *et al.*, (2004) reported TTSs of around 4 to 8 dB 5 minutes after exposure to 30 to 50 minutes of sound with SPL 160 dB re 1 μPa (EL about 193 to 195 dB re 1 μ^2-s). The difference in results was attributed to faster post-exposure threshold measurement—TTS may have recovered before being detected by Nachtigall *et al.*, (2003). These studies showed that, for long-duration exposures, lower sound pressures are required to induce TTS than are required for short-duration tones.
- Finneran *et al.*, (2000, 2002) conducted TTS experiments with dolphins and belugas exposed to impulsive sounds similar to those produced by distant underwater explosions and seismic waterguns. These studies showed that, for very short-duration impulsive sounds, higher sound pressures were required to induce TTS than for longer-duration tones.
- Finneran *et al.*, (2007) conducted TTS experiments with bottlenose dolphins exposed to intense 20 kHz fatiguing tone. Behavioral and auditory evoked potentials (using sinusoidal amplitude modulated tones creating auditory steady state response [AASR]) were used to measure TTS. The fatiguing tone was either 16 (mean = 193 re 1μPa, SD = 0.8) or 64 seconds (185–186 re 1μPa) in duration. TTS ranged from 19–33db from behavioral measurements and 40–45dB from ASSR measurements.
- Kastak *et al.*, (1999a, 2005) conducted TTS experiments with three species of pinnipeds, California sea lion, northern elephant seal and a Pacific harbor seal, exposed to continuous underwater sounds at levels of 80 and 95 dB sensation level at 2.5 and 3.5 kHz for up to 50 minutes. Mean TTS shifts of up to 12.2 dB occurred with the harbor seals showing the largest shift of 28.1 dB. Increasing the sound duration had a greater effect on TTS than increasing the sound level from 80 to 95 dB.

Some of the more important data obtained from these studies are onset-TTS levels (exposure levels sufficient to cause a just-measurable amount of TTS) often defined as 6 dB of TTS (for example, Schlundt *et al.*, 2000) and the fact that energy metrics (sound exposure levels (SEL), which include a duration component) better predict when an animal will sustain TTS than pressure (SPL) alone. NMFS' TTS criteria (which indicate the received level at which onset TTS (>6dB) is induced) for MFAS/HFAS are as follows:

- *Cetaceans*—195 dB re 1 μPa^2-s (based on mid-frequency cetaceans—no published data exist on auditory effects of noise in low-or high-frequency cetaceans (Southall *et al.*, (2007)).
- *Harbor Seals (and closely related species)*—183 dB re 1 μPa^2-s.
- *Northern Elephant Seals (and closely related species)*—204 dB re 1 μPa^2-s.
- *California Sea Lions (and closely related species)*—206 dB re 1 μPa^2-s.

A detailed description of how TTS criteria were derived from the results of the above studies may be found in Chapter 3 of Southall *et al.*, (2007), as well as the Navy's NWTRC LOA application. Because they are both otariids, the California sea lion criterion is used to estimate take of northern fur seals for this authorization.

Level A Harassment Threshold (PTS)

For acoustic effects, because the tissues of the ear appear to be the most susceptible to the physiological effects of sound, and because threshold shifts tend to occur at lower exposures than other more serious auditory effects, NMFS has determined that PTS is the best indicator for the smallest degree of injury that can be measured. Therefore, the acoustic exposure associated with onset-PTS is used to define the lower limit of the Level A harassment.

PTS data do not currently exist for marine mammals and are unlikely to be obtained due to ethical concerns. However, PTS levels for these animals may be estimated using TTS data from marine mammals and relationships between TTS and PTS that have been discovered through study of terrestrial mammals. NMFS uses the following acoustic criteria for injury:

- Cetaceans—215 dB re 1 μPa^2-s (based on mid-frequency cetaceans—no published data exist on auditory effects of noise in low-or high-frequency cetaceans (Southall *et al.*, (2007)).
- *Harbor Seals (and closely related species)*—203 dB re 1 μPa^2-s.
- *Northern Elephant Seals (and closely related species)*—224 dB re 1 μPa^2-s.
- *California Sea Lions (and closely related species)*—226 dB re 1 μPa^2-s.

These criteria are based on a 20 dB increase in SEL over that required for onset-TTS. Extrapolations from terrestrial mammal data indicate that PTS occurs at 40 dB or more of TS, and that TS growth occurs at a rate of approximately 1.6 dB TS per dB increase in EL. There is a 34-dB TS difference between onset-TTS (6 dB) and onset-PTS (40 dB). Therefore, an animal would require approximately 20dB of additional exposure (34 dB divided by 1.6 dB) above onset-TTS to reach PTS. A detailed description of how TTS criteria were derived from the results of the above studies may be found in Chapter 3 of Southall *et al.* (2007), as well as the Navy's NWTRC LOA application. Southall *et al.* (2007) recommend a precautionary dual criteria for TTS (230 dB re 1 µPa (SPL peak pressure) in addition to 215 dB re 1 μPa^2-s (SEL)) to account for the potentially damaging transients embedded within non-pulse exposures. However, in the case of MFAS/HFAS, the distance at which an animal would receive 215 dB (SEL) is farther from the source (*i.e.* , more conservative) than the distance at which they would receive 230 dB (SPL peak pressure) and therefore, it is not necessary to consider 230 dB peak.

We note here that behaviorally mediated injuries (such as those that have been hypothesized as the cause of some beaked whale strandings) could potentially occur in response to received levels lower than those believed to directly result in tissue damage. As mentioned previously, data to support a quantitative estimate of these potential effects (for which the exact mechanism is not known and in which factors other than received level may play a significant role) do not exist. However, based on the number of years (more than 40) and number of hours of MFAS per year that the U.S. (and other countries) has operated compared to the reported (and verified) cases of associated marine mammal strandings, NMFS believes that the probability of these types of injuries is very low (especially in the NWTRC, in which no major exercises using multiple surface vessel sources will occur and in which the surface vessel sonar use is less than 110 hours annually).

Level B Harassment Risk Function (Behavioral Harassment)

In 2006, NMFS issued the first MMPA authorization to allow the take of marine mammals incidental to MFAS (to the Navy for the Rim of the Pacific Exercises (RIMPAC)). For that authorization, NMFS used 173 dB SEL as the criterion for the onset of behavioral harassment (Level B Harassment). This type of single number criterion is referred to as a step function, in which (in this example) all animals estimated to be exposed to received levels above 173 db SEL would be predicted to be taken by Level B Harassment and all animals exposed to less than 173 dB SEL would not be taken by Level B Harassment. As mentioned previously, marine mammal behavioral responses to sound are highly variable and context specific (affected by differences in acoustic conditions; differences between species and populations; differences in gender, age, reproductive status, or social behavior; or the prior experience of the individuals), which does not support the use of a step function to estimate behavioral harassment.

Unlike step functions, acoustic risk continuum functions (which are also called ''exposure-response functions,'' ''dose-response functions,'' or ''stress-response functions'' in other risk assessment contexts) allow for probability of a response that NMFS would classify as harassment to occur over a range of possible received levels (instead of one number) and assume that the probability of a response depends first on the ''dose'' (in this case, the received level of sound) and that the probability of a response increases as the ''dose'' increases (*see* Figure 1a). In January 2009, NMFS issued 3 final rules governing the incidental take of marine mammals (Navy's Hawaii Range Complex, Southern California Range Complex, and Atlantic Fleet Active Sonar Training) that used a risk continuum to estimate the percentage of marine mammals exposed to various levels of MFAS that would respond in a manner NMFS considers harassment. The Navy and NMFS have previously used acoustic risk functions to estimate the probable responses of marine mammals to acoustic exposures for other training and research programs. Examples of previous application include the Navy FEISs on the SURTASS LFA sonar (U.S. Department of the Navy, 2001c); the North Pacific Acoustic Laboratory experiments conducted off the Island of Kauai (Office of Naval Research, 2001), and the Supplemental EIS for SURTASS LFA sonar (U.S. Department of the Navy, 2007d). As discussed in the Effects section, factors other than received level (such as distance from or bearing to the sound source) can affect the way that marine mammals respond; however, data to support a quantitative analysis of those (and other factors) do not currently exist. NMFS will continue to modify these criteria as new data that meet NMFS standards of quality become available and can be appropriately and effectively incorporated.

The particular acoustic risk functions developed by NMFS and the Navy (*see* Figures 1a and 1b) estimate the probability of behavioral responses to MFAS/HFAS (interpreted as the percentage of the exposed population) that NMFS would classify as harassment for the purposes of the MMPA given exposure to specific received levels of MFAS/HFAS. The mathematical function (below) underlying this curve is a cumulative probability distribution adapted from a solution in Feller (1968) and was also used in predicting risk for the Navy's SURTASS LFA MMPA authorization as well.

$$R = \frac{1-\left(\frac{L-B}{K}\right)^{-A}}{1-\left(\frac{L-B}{K}\right)^{-2A}}$$

Where:

R = Risk (0–1.0)
L = Received level (dB re: 1 μPa)
B = Basement received level = 120 dB re: 1 μPa
K = Received level increment above B where 50-percent risk = 45 dB re: 1 μPa
A = Risk transition sharpness parameter = 10 (odontocetes and pinnipeds) or 8 (mysticetes)

In order to use this function to estimate the percentage of an exposed population that would respond in a manner that NMFS classifies as Level B Harassment, based on a given received level, the values for B, K and A need to be identified.

B Parameter (Basement)—The B parameter is the estimated received level below which the probability of disruption of natural behavioral patterns, such as migration, surfacing, nursing, breeding, feeding, or sheltering, to a point where such behavioral patterns are abandoned or significantly altered approaches zero for the MFAS/HFAS risk assessment. At this received level, the curve would predict that the percentage of the exposed population that would be taken by Level B Harassment approaches zero. For MFAS/HFAS, NMFS has determined that B = 120 dB. This level is based on a broad overview of the levels at which many species have been reported responding to a variety of sound sources.

K Parameter (representing the 50 percent Risk Point)—The K parameter is based on the received level that corresponds to 50% risk, or the received level at which we believe 50% of the animals exposed to the designated received level will respond in a manner that NMFS classifies as Level B Harassment. The K parameter (K = 45 dB) is based on three data sets in which marine mammals exposed to mid-frequency sound sources were reported to respond in a manner that NMFS would classify as Level B Harassment. There is widespread consensus that marine mammal responses to MFA sound signals need to be better defined using controlled exposure experiments (Cox *et al.*, 2006; Southall *et al.*, 2007). The Navy is contributing to an ongoing 3-Phase behavioral response study in the Bahamas that is expected to provide some initial information on beaked whales, the species identified as the most sensitive to MFAS. NMFS is leading this international effort with scientists from various academic institutions and research organizations to conduct studies on how marine mammals respond to underwater sound exposures. The results from Phase 1 of this study are discussed in the Potential Effects of Specified Activities on Marine Mammals section and the results from Phase 2 are expected to be available in the fall of 2009. Phase 3 will be conducted in the Mediterranean Sea in summer 2009. Additionally, the Navy recently tagged whales in conjunction with the 2008 RIMPAC exercises; however, analysis of these data is not yet complete. Until additional appropriate data are available, however, NMFS and the Navy have determined that the following three data sets are most applicable for direct use in establishing the K parameter for the MFAS/HFAS risk function. These data sets, summarized below, represent the only known data that specifically relate altered behavioral responses (that NMFS would consider Level B Harassment) to exposure—at specific received levels—to MFAS and sources within or having components within the range of MFAS (1–10 kHz).

Even though these data are considered the most representative of the proposed specified activities, and therefore the most appropriate on which to base the K parameter (which basically determines the midpoint) of the risk function, these data have limitations, which are discussed in Appendix D of the Navy's DEIS for NWTRC.

1. *Controlled Laboratory Experiments with Odontocetes (SSC Data set)*—Most of the observations of the behavioral responses of toothed whales resulted from a series of controlled experiments on bottlenose dolphins and beluga whales conducted by researchers at SSC's facility in San Diego, California (Finneran *et al.*, 2001, 2003, 2005; Finneran and Schlundt, 2004; Schlundt *et al.*, 2000). In experimental trials (designed to measure TTS) with marine mammals trained to perform tasks when prompted, scientists evaluated whether the marine mammals still performed these tasks when exposed to mid-frequency tones. Altered behavior during experimental trials usually involved refusal of animals to return to the site of the sound stimulus, but also included attempts to avoid an exposure in progress, aggressive behavior, or refusal to further participate in tests.

Finneran and Schlundt (2004) examined behavioral observations recorded by the trainers or test coordinators during the Schlundt *et al.*, (2000) and Finneran *et al.*, (2001, 2003, 2005) experiments. These included observations from 193 exposure sessions (fatiguing stimulus level > 141 dB re 1 μPa) conducted by Schlundt *et al.*, (2000) and 21 exposure sessions conducted by Finneran *et al.*, (2001, 2003, 2005). The TTS experiments that supported Finneran and Schlundt (2004) are further explained below:

- Schlundt *et al.*, (2000) provided a detailed summary of the behavioral responses of trained marine mammals during TTS tests conducted at SSC San Diego with 1-sec tones and exposure frequencies of 0.4 kHz, 3 kHz, 10 kHz, 20 kHz and 75 kHz. Schlundt *et al.*, (2000) reported eight individual TTS experiments. The experiments were conducted in San Diego Bay. Because of the variable ambient noise in the bay, low-level broadband masking noise was used to keep hearing thresholds consistent despite fluctuations in the ambient noise. Schlundt *et al.*, (2000) reported that ''behavioral alterations,'' or deviations from the behaviors the animals being tested had been trained to exhibit, occurred as the animals were exposed to increasing fatiguing stimulus levels.
- Finneran *et al.*, (2001, 2003, 2005) conducted 2 separate TTS experiments using 1-sec tones at 3 kHz. The test methods were similar to that of Schlundt *et al.*, (2000) except the tests were conducted in a pool with very low ambient noise level (below 50 dB re 1 μPa^2/hertz [Hz]), and no masking noise was used. In the first, fatiguing sound levels were increased from 160 to 201 dB SPL. In the second experiment, fatiguing sound levels between 180 and 200 dB SPL were randomly presented.

Bottlenose dolphins exposed to 1-second (sec) intense tones exhibited short-term changes in behavior above received sound levels of 178 to 193 dB re 1 μPa (rms), and beluga whales did so at received levels of 180 to 196 dB and above.

2. *Mysticete Field Study (Nowacek et al., 2004)*—The only available and applicable data relating mysticete responses to exposure to mid-frequency sound sources is from Nowacek *et al.*, (2004). Nowacek *et al.*, (2004) documented observations of the behavioral response of North Atlantic right whales exposed to alert stimuli containing mid-frequency components in the Bay of Fundy. Investigators used archival digital acoustic recording tags (DTAG) to record the behavior (by measuring pitch, roll, heading, and depth) of right whales in the presence of an alert signal, and to calibrate received sound levels. The alert signal was 18 minutes of exposure consisting of three 2-minute signals played sequentially three times over. The three signals had a 60% duty cycle and

consisted of: (1) Alternating 1-sec pure tones at 500 Hz and 850 Hz; (2) a 2-sec logarithmic down-sweep from 4,500 Hz to 500 Hz; and (3) a pair of low (1,500 Hz)-high (2,000 Hz) sine wave tones amplitude modulated at 120 Hz and each 1-sec long. The purposes of the alert signal were (a) to pique the mammalian auditory system with disharmonic signals that cover the whales' estimated hearing range; (b) to maximize the signal to noise ratio (obtain the largest difference between background noise) and (c) to provide localization cues for the whale. The maximum source level used was 173 dB SPL.

Nowacek *et al.* (2004) reported that five out of six whales exposed to the alert signal with maximum received levels ranging from 133 to 148 dB re 1 μPa significantly altered their regular behavior and did so in identical fashion. Each of these five whales: (i) Abandoned their current foraging dive prematurely as evidenced by curtailing their 'bottom time'; (ii) executed a shallow-angled, high power (*i.e.,* significantly increased fluke stroke rate) ascent; (iii) remained at or near the surface for the duration of the exposure, an abnormally long surface interval; and (iv) spent significantly more time at subsurface depths (1–10 m) compared with normal surfacing periods when whales normally stay within 1 m (1.1 yd) of the surface.

3. *Odontocete Field Data (Haro Strait—USS SHOUP)*—In May 2003, killer whales (*Orcinus orca*) were observed exhibiting behavioral responses generally described as avoidance behavior while the U.S. Ship (USS) SHOUP was engaged in MFAS in the Haro Strait in the vicinity of Puget Sound, Washington. Those observations have been documented in three reports developed by Navy and NMFS (NMFS, 2005; Fromm, 2004a, 2004b; DON, 2003). Although these observations were made in an uncontrolled environment, the sound field that may have been associated with the active sonar operations was estimated using standard acoustic propagation models that were verified (for some but not all signals) based on calibrated *in situ* measurements from an independent researcher who recorded the sounds during the event. Behavioral observations were reported for the group of whales during the event by an experienced marine mammal biologist who happened to be on the water studying them at the time. The observations associated with the USS SHOUP provide the only data set available of the behavioral responses of wild, non-captive animal upon actual exposure to AN/SQS–53 sonar.

U.S. Department of Commerce (National Marine Fisheries, 2005a); U.S. Department of the Navy (2004b); and Fromm (2004a, 2004b) documented reconstruction of sound fields produced by USS SHOUP associated with the behavioral response of killer whales observed in Haro Strait. Observations from this reconstruction included an approximate closest approach time which was correlated to a reconstructed estimate of received level. Observations from this reconstruction included an estimate of 169.3 dB SPL which represents the mean level at a point of closest approach within a 500 m wide area in which the animals were exposed. Within that area, the estimated received levels varied from approximately 150 to 180 dB SPL.

Calculation of K Parameter—NMFS and the Navy used the mean of the following values to define the midpoint of the function: (1) The mean of the lowest received levels (185.3 dB) at which individuals responded with altered behavior to 3 kHz tones in the SSC data set; (2) the estimated mean received level value of 169.3 dB produced by the reconstruction of the USS SHOUP incident in which killer whales exposed to MFAS (range modeled possible received levels: 150 to 180 dB); and (3) the mean of the 5 maximum received levels at which Nowacek *et al.* (2004) observed significantly altered responses of right whales to the alert stimuli than to the control (no input signal) is 139.2 dB SPL. The arithmetic mean of these three mean values is 165 dB SPL. The value of K is the difference between the value of B (120 dB SPL) and the 50% value of 165 dB SPL; therefore, K = 45.

A Parameter (Steepness)—NMFS determined that a steepness parameter (A) = 10 is appropriate for odontocetes (except harbor porpoises) and pinnipeds and A = 8 is appropriate for mysticetes.

The use of a steepness parameter of A = 10 for odontocetes for the MFAS/HFAS risk function was based on the use of the same value for the SURTASS LFA risk continuum, which was supported by a sensitivity analysis of the parameter presented in Appendix D of the SURTASS/LFA FEIS (U.S. Department of the Navy, 2001c). As concluded in the SURTASS FEIS/EIS, the value of A = 10 produces a curve that has a more gradual transition than the curves developed by the analyses of migratory gray whale studies (Malme *et al.*, 1984; Buck and Tyack, 2000; and SURTASS LFA Sonar EIS, Subchapters 1.43, 4.2.4.3 and Appendix D, and National Marine Fisheries Service, 2008).

NMFS determined that a lower steepness parameter (A = 8), resulting in a shallower curve, was appropriate for use with mysticetes and MFAS/HFAS. The Nowacek *et al.* (2004) data set contains the only data illustrating mysticete behavioral responses to a sound source that encompasses frequencies in the mid-frequency sound spectrum. A shallower curve (achieved by using A = 8) better reflects the risk of behavioral response at the relatively low received levels at which behavioral responses of right whales were reported in the Nowacek *et al.* (2004) data. Compared to the odontocete curve, this adjustment results in an increase in the proportion of the exposed population of mysticetes being classified as behaviorally harassed at lower RLs, such as those reported in and supported by the only data set currently available.

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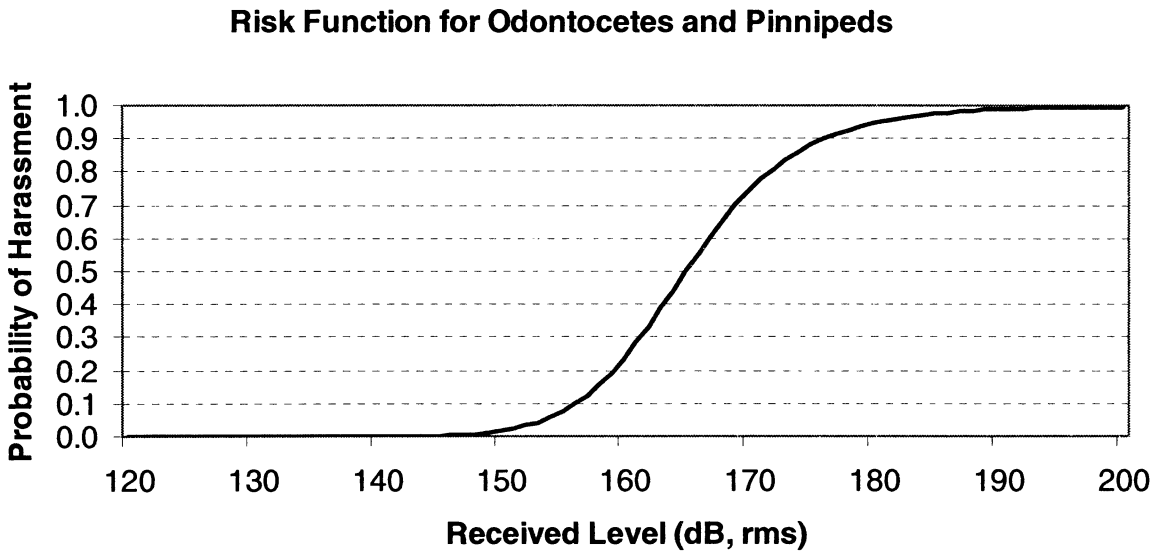

Figure 1a. Risk function for odontocetes and pinnipeds. B=120 dB, K=45 dB, A=10

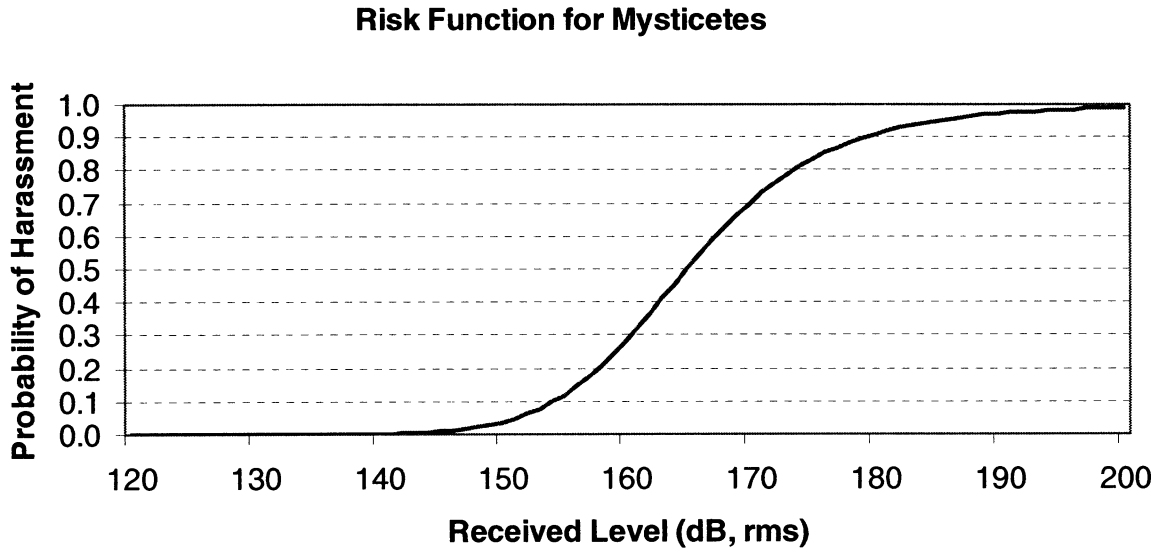

Figure 1b. Risk function for mysticetes. B=120 dB, K=45 dB, A=8.

Basic Application of the Risk Function—The risk function is used to estimate the percentage of an exposed population that is likely to exhibit behaviors that would qualify as harassment (as that term is defined by the MMPA applicable to military readiness activities, such as the Navy's testing and training with MFAS) at a given received level of sound. For example, at 165 dB SPL (dB re: 1µPa rms), the risk (or probability) of harassment is defined according to this function as 50%, and Navy/NMFS applies that by estimating that 50% of the individuals exposed at that received level are likely to respond by exhibiting behavior that NMFS would classify as behavioral harassment. The risk function is not applied to individual animals, only to exposed populations.

The data primarily used to produce the risk function (the K parameter) were compiled from four species that had been exposed to sound sources in a variety of different circumstances. As a result, the risk function represents a general relationship between acoustic exposures and behavioral responses that

is then applied to specific circumstances. That is, the risk function represents a relationship that is deemed to be generally true, based on the limited, best-available science, but may not be true in specific circumstances. In particular, the risk function, as currently derived, treats the received level as the only variable that is relevant to a marine mammal's behavioral response. However, we know that many other variables—the marine mammal's gender, age, and prior experience; the activity it is engaged in during an exposure event, its distance from a sound source, the number of sound sources, and whether the sound sources are approaching or moving away from the animal—can be critically important in determining whether and how a marine mammal will respond to a sound source (Southall *et al.*, 2007). The data that are currently available do not allow for incorporation of these other variables in the current risk functions; however, the risk function represents the best use of the data that are available. Additionally, although these other factors cannot be taken into consideration quantitatively in the risk function, NMFS considers these other variables qualitatively in our analysis, when applicable data are available.

As more specific and applicable data become available for MFAS/HFAS sources, NMFS can use these data to modify the outputs generated by the risk function to make them more realistic. Ultimately, data may exist to justify the use of additional, alternate, or multi-variate functions. For example, as mentioned previously, the distance from the sound source and whether it is perceived as approaching or moving away can affect the way an animal responds to a sound (Wartzok *et al.*, 2003). In the NWTRC example, animals exposed to received levels between 120 and 140 dB may be 28–70 nm (51–130 km) from a sound source depending on seasonal variations; those distances could influence whether those animals perceive the sound source as a potential threat, and their behavioral responses to that threat. Though there are data showing response of certain marine mammal species to mid-frequency sound sources at that received level, NMFS does not currently have any data that describe the response of marine mammals to mid-frequency sounds at that distance, much less data that compare responses to similar sound levels at varying distances (much less for MFAS/HFAS). However, if applicable data meeting NMFS standards were to become available, NMFS would re-evaluate the risk function and to incorporate any additional variables into the ''take'' estimates.

Harbor Porpoise Behavioral Harassment Criteria

The information currently available regarding these inshore species that inhabit shallow and coastal waters suggests a very low threshold level of response for both captive and wild animals. Threshold levels at which both captive (*e.g.* Kastelein *et al.*, 2000; Kastelein *et al.*, 2005; Kastelein *et al.*, 2006, Kastelein *et al.*, 2008) and wild harbor porpoises (*e.g.* Johnston, 2002) responded to sound (*e.g.* acoustic harassment devices (ADHs), acoustic deterrent devices (ADDs), or other non-pulsed sound sources) is very low (*e.g.* ~120 dB SPL), although the biological significance of the disturbance is uncertain. Therefore, a step function threshold of 120 dB SPL was used to estimate take of harbor porpoises instead of the risk functions used for other species (*i.e.*, we assume for the purpose of estimating take that all harbor porpoises exposed to 120 dB or higher MFAS/HFAS will be taken by Level B behavioral harassment).

Explosive Detonation Criteria

The criteria for mortality, Level A Harassment, and Level B Harassment resulting from explosive detonations were initially developed for the Navy's Seawolf and Churchill ship-shock trials and have not changed since other MMPA authorizations issued for explosive detonations. The criteria, which are applied to cetaceans and pinnipeds, are summarized in Table 7. Additional information regarding the derivation of these criteria is available in the Navy's DEIS for the NWTRC, the LOA application, and in the Navy's CHURCHILL FEIS (U.S. Department of the Navy, 2001c).

Type of Effect	Criteria	Metric	Threshold	MMPA
Mortality	Onset of Extensive Lung Injury	Goertner modified positive impulse	indexed to 30.5 psi-msec (assumes 100 percent small animal at 26.9 lbs)	Mortality
Injurious Physiological	50% Tympanic Membrane Rupture	Energy flux density	1.17 in-lb/in^2 (about 205 dB re 1 microPa^2-sec)	Level A Harassment
Injurious Physiological	Onset Slight Lung Injury	Goertner modified positive impulse	indexed to 13 psi-msec (assumes 100 percent small animal at 26.9 lbs)	Level A Harassment
Non-injurious Physiological	TTS	Greatest energy flux density level in any 1/3-octave band (> 100 Hz for toothed whales and > 10 Hz for baleen whales) - for total energy over all exposures	182 dB re 1 microPa^2-sec	Level B Harassment
Non-injurious Physiological	TTS	Peak pressure over all exposures	23 psi	Level B Harassment
Non-injurious Behavioral	Multiple Explosions Without TTS	Greatest energy flux density level in any 1/3-octave (> 100 Hz for toothed whales and > 10 Hz for baleen whales) - for total energy over all exposures (multiple explosions only)	177 dB re 1 microPa^2-sec	Level B Harassment

Table 7. Summary of Explosive Criteria

Estimates of Potential Marine Mammal Exposure

Estimating the take that will result from the proposed activities entails the following three general steps: (1) Propagation model estimates animals exposed to sources at different levels; (2) further modeling determines number of exposures to levels indicated in criteria above (*i.e.*, number of takes); and (3) post-modeling corrections refine estimates to make them more accurate. More information regarding the models used, the assumptions used in the models, and the process of estimating take is available in Appendix D of the Navy's DEIS for NWTRC.

(1) In order to quantify the types of take described in previous sections that are predicted to result from the Navy's specified activities, the Navy first uses a sound propagation model that predicts the number of animals that will be exposed to a range of levels of pressure and energy (of the metrics used in the criteria) from MFAS/HFAS and explosive detonations based on several important pieces of information, including:

- Characteristics of the sound sources.
- Active sonar source characteristics include: Source level (with horizontal and vertical directivity corrections), source depth, center frequency, source directivity (horizontal/vertical beam width and horizontal/vertical steer direction), and ping spacing.
- Explosive source characteristics include: The weight of an explosive, the type of explosive, the detonation depth, number of successive explosions.
- Transmission loss (in 16 representative environmental provinces in two seasons) based on: Water depth; sound speed variability throughout the water column (warm season exhibits a weak surface duct, cold season exhibits a relatively strong surface duct); bottom geo-acoustic properties (bathymetry); and wind speed.
- The estimated density of each marine mammal species in the NWTRC (*see* Table 4), horizontally distributed uniformly and vertically distributed according to dive profiles based on field data.

(2) Next, the criteria discussed in the previous section are applied to the estimated exposures to predict the number of exposures that exceed the criteria, *i.e.*, the number of takes by Level B Harassment, Level A Harassment, and mortality.

(3) During the development of the EIS for NWTRC, NMFS and the Navy determined that the output of the model could be made more realistic by applying post-modeling corrections to account for the following:

- Acoustic footprints for active sonar sources must account for land masses (by subtracting them out).
- Acoustic footprints for active sonar sources should not be added independently; rather, the degree to which the footprints from multiple ships participating in the same exercise would typically overlap needs to be taken into consideration.
- Acoustic modeling should account for the maximum number of individuals of a species that could potentially be exposed to active sonar within the course of 1 day or a discreet continuous sonar event if less than 24 hours.

Last, the Navy's specified activities have been described based on best estimates of the number of MFAS/HFAS hours that the Navy will conduct. The exact number of hours may vary from year to year but will not exceed the 5-year total indicated in Table 8 (by multiplying the yearly estimate by 5) by

more than 10%. NMFS estimates that a 10-percent increase in active sonar hours would result in approximately a 10-percent increase in the number of takes, and we have considered this possibility in our analysis.

The Navy's model provides a systematic and repeatable way of estimating the number of animals that will be taken by Level A and Level B Harassment. The model is based on the sound propagation characteristics of the sound sources, physical characteristics of the surrounding environment, and a uniform density of marine mammals. As mentioned in the previous sections, many other factors will likely affect how and the degree to which marine mammals are impacted both at the individual and species level by the Navy's activity (such as social ecology of the animals, long term exposures in one area, *etc.*); however, in the absence of quantitative data, NMFS has, and will continue, to evaluate that sort of information qualitatively.

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Species	Modeled Sonar Exposures to Indicated Thresholds			Modeled Explosive Exposures to Indicated Thresholds				NMFS Proposed Annual Take Authorization		
	Level B Exposures		Level A Exposures	Level B Exposures		Level A Exposures	Mortality	Level B Harassment	Level A Harassment	Mortality
	Risk Function	TTS		Sub-TTS	TTS					
ESA-listed / MMPA depleted Species										
Blue whale	17	0	0	1	1	1	0	19	1	0
Fin whale	123	2	0	12	7	1	0	144	1	0
Humpback whale	15	0	0	0	0	0	0	15	0	0
Killer Whale	14	0	0	0	0	0	0	14	0	0
Sei whale	1	0	0	0	0	0	0	1	0	0
Sperm whale	102	2	0	13	10	1	0	127	1	0
Steller Sea Lion	114	0	0	3	3	1	0	120	1	0
Mysticetes										
Gray whale	4	0	0	0	0	0	0	4	0	0
Minke whale	9	0	0	0	0	0	0	9	0	0
Odontocetes										
Baird's beaked whale	12	0	0	1	0	0	0	13	0	0
Bottlenose dolphin	0	0	0	0	0	0	0	0	0	0
Cuvier's beaked whale	12	0	0	1	1	0	0	14	0	0
Dall's porpoise	4,485	147	0	62	58	3	0	4752	3	0
Dwarf / Pygmy sperm whale	3	0	0	1	0	0	0	4	0	0
Harbor porpoise*	119,215	45	0	9	5	1	0	119274	1	0
Mesoplodon spp.	14	0	0	1	0	0	0	15	0	0
Northern right whale dolphin	705	18	0	11	7	1	0	741	1	0
Pacific white-sided dolphin	537	23	0	8	3	0	0	571	0	0
Risso's dolphin	85	2	0	9	4	0	0	100	0	0
Short beaked common dolphin	1,142	42	0	49	23	2	0	1256	2	0
Short-finned pilot whale	2	0	0	0	0	0	0	2	0	0
Striped dolphin	38	1	0	0	1	0	0	40	0	0
Pinnipeds										
Northern elephant seal	296	0	0	53	29	2	0	378	2	0
Pacific harbor seal	294	290	1	2	0	0	0	586	1	0
California sea lion	283	0	0	2	1	0	0	286	0	0
Northern fur seal	1,296	1	0	24	44	1	0	1365	1	0
Total	128,583	528	1	262	197	12	0	129570	13	0

Table 8. Annual Navy estimated and NMFS proposed authorized take of marine mammals.

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Mortality

Evidence from five beaked whale strandings, all of which have taken place outside the NWTRC Range Complex, and have occurred over approximately a decade, suggests that the exposure of beaked whales to MFAS in the presence of certain conditions (*e.g.*, multiple units using active sonar, steep bathymetry, constricted channels, strong surface ducts, etc.) may result in strandings, potentially leading to mortality. Although these physical

factors believed to have contributed to the likelihood of beaked whale strandings are not present, in their aggregate, in the NWTRC, scientific uncertainty exists regarding what other factors, or combination of factors, may contribute to beaked whale strandings. However, because none of the MFAS/HFAS ASW exercises conducted in the NWTRC are major exercises employing multiple surface vessels, the exercises last 1.5 hours or less, and only 65 exercises are planned (for a total of about 100 hours of surface vessel sonar operation), NMFS and the Navy believe it is highly unlikely that marine mammals would respond to these exercises in a manner that would result in a stranding. Therefore, no authorization for mortality has been requested or proposed.

Effects on Marine Mammal Habitat

The Navy's proposed training exercises could potentially affect marine mammal habitat through the introduction of pressure, sound, and expendable materials into the water column, which in turn could impact prey species of marine mammals, or cause bottom disturbance or changes in water quality. Each of these components was considered in the NWTRC DEIS and was determined by the Navy to have no effect on marine mammal habitat. Based on the information below and the supporting information included in the Navy's DEIS, NMFS has preliminarily determined that the NWTRC training activities will not have significant or long term impacts on marine mammal habitat. Unless the sound source or explosive detonation is stationary and/or continuous over a long duration in one area, the effects of the introduction of sound into the environment are generally considered to have a less severe impact on marine mammal habitat than the physical alteration of the habitat. Marine mammals may be temporarily displaced from areas where Navy training is occurring, but the area will likely be utilized again after the activities have ceased. A summary of the conclusions are included in subsequent sections.

Critical Habitat

Critical Habitat has been designated for 2 species in the NWTRC, southern resident killer whales (in the inshore area) and Steller sea lions (3 haulouts near the southern end of the offshore area). No sonar training is planned for the inshore area and explosive use will be limited to 4 detonations of small 2.5-lb charges annually. The Navy plans to abide by the 3000-ft air and water stand-off distances associated with the Steller sea lion critical habitat. Effects to designated critical habitat will be fully analyzed in the Navy's ESA Section 7 consultation for the NWTRC.

Effects on Food Resources

Fish

The Navy's DEIS includes a detailed discussion of the effects of active sonar on marine fish. In summary, studies have indicated that acoustic communication and orientation of fish may be restricted by anthropogenic sound in their environment. However, the vast majority of fish species studied to date are hearing generalists and cannot hear sounds above 500 to 1,500 Hz (0.5 to 1.5 kHz) (depending upon the species). Therefore, these fish species are not likely to be affected behaviorally from higher frequency sounds such as MFAS/HFAS. Moreover, even those marine species that may hear above 1.5 kHz, such as a few sciaenids and the clupeids (and relatives), have relatively poor hearing above 1.5 kHz as compared to their hearing sensitivity at lower frequencies, so it is likely that the fish will only actually hear the sounds if the fish and source were fairly close to one another. Finally, since the vast majority of sounds that are of biological relevance to fish are below 1 kHz (*e.g.*, Zelick *et al.*, 1999; Ladich and Popper, 2004), even if a fish detects a mid- or high-frequency sound, these sounds will not likely mask detection of lower frequency biologically relevant sounds. Thus, based on the available information, a reasonable conclusion is that there will be few, and more likely no, impacts on the behavior of fish from active sonar.

Though mortality has been shown to occur in one species, a hearing specialist, as a result of exposure to non-impulsive sources, the available evidence does not suggest that exposures such as those anticipated from MFAS/HFAS would result in significant fish mortality on a population level. The mortality that was observed was considered insignificant in light of natural daily mortality rates. Experiments have shown that exposure to loud sound can result in significant threshold shifts in certain fish that are classified as hearing specialists (but not those classified as hearing generalists). Threshold shifts are temporary, and considering the best available data, no data exist that demonstrate any long-term negative effects on marine fish from underwater sound associated with active sonar activities. Further, while fish may respond behaviorally to mid-frequency sources, this behavioral modification is only expected to be brief and not biologically significant.

There are currently no well-established thresholds for estimating effects to fish from explosives other than mortality models. Fish that are located in the water column, in proximity to the source of detonation could be injured, killed, or disturbed by the impulsive sound and possibly temporarily leave the area. Continental Shelf Inc. (2004) summarized a few studies conducted to determine effects associated with removal of offshore structures (*e.g.*, oil rigs) in the Gulf of Mexico. Their findings revealed that at very close range, underwater explosions are lethal to most fish species regardless of size, shape, or internal anatomy. For most situations, cause of death in fishes has been massive organ and tissue damage and internal bleeding. At longer range, species with gas-filled swimbladders (*e.g.*, snapper, cod, and striped bass) are more susceptible than those without swimbladders (*e.g.*, flounders, eels). Studies also suggest that larger fishes are generally less susceptible to death or injury than small fishes. Moreover, elongated forms that are round in cross section are less at risk than deep-bodied forms; and orientation of fish relative to the shock wave may affect the extent of injury. Open water pelagic fish (*e.g.*, mackerel) also seem to be less affected than reef fishes. The results of most studies are dependent upon specific biological, environmental, explosive, and data recording factors.

The huge variations in the fish population, including numbers, species, sizes, and orientation and range from the detonation point, make it very difficult to accurately predict mortalities at any specific site of detonation. As mentioned previously, though, only 4 small detonations are planned for the inshore area and the exercises involving larger detonations are conducted far offshore. Most fish species experience a large number of natural mortalities, especially during early life-stages, and any small level of mortality caused by the NWTRC training exercises involving explosives will likely be insignificant to the population as a whole.

Invertebrates

Very little is known about sound detection and use of sound by invertebrates (*see* Budelmann 1992a, b, Popper *et al.*, 2001 for reviews). The limited data shows that some crabs are able to detect sound, and there has been the suggestion that some other groups of invertebrates are also able to detect sounds. In addition, cephalopods (octopus and squid) and decapods (lobster, shrimp, and crab) are thought

to sense low-frequency sound (Budelmann, 1992b). Packard *et al.* (1990) reported sensitivity to sound vibrations between 1–100 Hz for three species of cephalopods. McCauley *et al.* (2000) found evidence that squid exposed to seismic airguns show a behavioral response including inking. However, these were caged animals, and it is not clear how unconfined animals may have responded to the same signal and at the same distances used. In another study, Wilson *et al.* (2007) played back echolocation clicks of killer whales to two groups of squid (*Loligo pealeii*) in a tank. The investigators observed no apparent behavioral effects or any acoustic debilitation from playback of signals up to 199 to 226 dB re 1 µPa. It should be noted, however, that the lack of behavioral response by the squid may have been because the animals were in a tank rather than being in the wild. In another report on squid, Guerra *et al.* (2004) claimed that dead giant squid turned up around the time of seismic airgun operations off of Spain. The authors suggested, based on analysis of carcasses, that the damage to the squid was unusual when compared to other dead squid found at other times. However, the report presents conclusions based on a correlation to the time of finding of the carcasses and seismic testing, but the evidence in support of an effect of airgun activity was totally circumstantial. Moreover, the data presented showing damage to tissue is highly questionable since there was no way to differentiate between damage due to some external cause (*e.g.*, the seismic airgun) and normal tissue degradation that takes place after death, or due to poor fixation and preparation of tissue. To date, this work has not been published in peer reviewed literature, and detailed images of the reportedly damaged tissue are also not available.

In summary, baleen whales feed on the aggregations of krill and small schooling fish, while toothed whales feed on epipelagic, mesopelagic, and bathypelagic fish and squid. As summarized above and in the NWTRC EIS/OEIS in more detail, potential impacts to marine mammal food resources within the NWTRC is negligible given both lack of hearing sensitivity to mid-frequency sonar, the very geographic and spatially limited scope of most Navy at sea activities including underwater detonations, and the high biological productivity of these resources. No short or long term effects to marine mammal food resources from Navy activities are anticipated within the NWTRC.

Military Expendable Material

Marine mammals are subject to entanglement in expended materials, particularly anything incorporating loops or rings, hooks and lines, or sharp objects. Most documented cases of entanglements occur when whales encounter the vertical lines of fixed fishing gear. This section summarizes the potential effects of expended materials on marine mammals. Detailed discussion of military expendable material is contained within the NWTRC EIS.

The Navy endeavors to recover expended training materials. Notwithstanding, it is not possible to recover all training materials, and some may be encountered by marine mammals in the waters of the NWTRC. Debris related to military activities that is not recovered generally sinks; the amount that might remain on or near the sea surface is low, and the density of such expendable materials in the NWTRC would be very low. Types of training materials that might be encountered include: Parachutes of various types (*e.g.*, those employed by personnel or on targets, flares, or sonobuoys); torpedo guidance wires, torpedo ''flex hoses;'' cable assemblies used to facilitate target recovery; sonobuoys; and EMATT. Although sunken debris might be of increased concern for bottom-feeding marine mammals, like the gray whale, again, the low density is such that it is very unlikely that animals would interact with any of these materials.

Entanglement in military expendable material was not cited as a source of injury or mortality for any marine mammals recorded in a large marine mammal and sea turtle stranding database for California waters, an area with much higher density of marine mammals. Therefore as discussed in the NWTRC EIS, expendable material is highly unlikely to directly affect marine mammal species or potential habitat within the NWTRC.

NMFS Office of Habitat Conservation is working with the Navy to better identify the potential risks of expended materials from the Navy activities as they relate to Essential Fish Habitat. These effects are indirectly related to marine mammal habitat, but based on the extent of the likely effects described in the Navy's DEIS, NMFS' Office of Protected Resources has preliminarily determined that they will not result in significant impacts to marine mammal habitat. The outcome of this consultation will further inform the marine mammal habitat analysis in the final rule.

Water Quality

The NWTRC EIS/OEIS analyzed the potential effects to water quality Expendable Mobile ASW Training Target (EMATT) batteries. In addition, sonobuoys were not analyzed since, once scuttled, their electrodes are largely exhausted during use and residual constituent dissolution occurs more slowly than the releases from activated seawater batteries. As such, only the potential effects of batteries and explosions on marine water quality in and surrounding the sonobuoy training area were completed. It was determined that there would be no significant effect to water quality from seawater batteries, lithium batteries, and thermal batteries associated with scuttled sonobuoys.

EMATTs use lithium sulfur dioxide batteries. The constituents in the battery react to form soluble hydrogen gas and lithium dithionite. The hydrogen gas eventually enters the atmosphere and the lithium hydroxide dissociates, forming lithium ions and hydroxide ions. The hydroxide is neutralized by the hydronium formed from hydrolysis of the acidic sulfur dioxide, ultimately forming water. Sulfur dioxide, a gas that is highly soluble in water, is the major reactive component in the battery. The sulfur ioxide ionizes in the water, forming bisulfite (HSO3) that is easily oxidized to sulfate in the slightly alkaline environment of the ocean. Sulfur is present as sulfate in large quantities (*i.e.*, 885 milligrams per liter [mg/L]) in the ocean. Thus, it was determined that there would be no significant effect to water quality from lithium sulfur batteries associated with scuttled EMATTs.

Analysis and Negligible Impact Determination

Pursuant to NMFS' regulations implementing the MMPA, an applicant is required to estimate the number of animals that will be ''taken'' by the specified activities (*i.e.*, takes by harassment only, or takes by harassment, injury, and/or death). This estimate informs the analysis that NMFS must perform to determine whether the activity will have a ''negligible impact'' on the affected species or stock. Level B (behavioral) harassment occurs at the level of the individual(s) and does not assume any resulting population-level consequences, though there are known avenues through which behavioral disturbance of individuals can result in population-level effects (for example: Pink-footed geese (*Anser brachyrhynchus*) in undisturbed habitat gained body mass and had about a 46-

percent reproductive success compared with geese in disturbed habitat (being consistently scared off the fields on which they were foraging) which did not gain mass and has a 17-percent reproductive success). A negligible impact finding is based on the lack of likely adverse effects on annual rates of recruitment or survival (*i.e.*, population-level effects). An estimate of the number of Level B harassment takes, alone, is not enough information on which to base an impact determination. In addition to considering estimates of the number of marine mammals that might be ''taken'' through behavioral harassment, NMFS must consider other factors, such as the likely nature of any responses (their intensity, duration, *etc.*), the context of any responses (critical reproductive time or location, migration, *etc.*), as well as the number and nature of estimated Level A takes, the number of estimated mortalities, and effects on habitat. Generally speaking, and especially with other factors being equal, the Navy and NMFS anticipate more severe effects from takes resulting from exposure to higher received levels (though this is in no way a strictly linear relationship throughout species, individuals, or circumstances) and less severe effects from takes resulting from exposure to lower received levels.

The Navy's specified activities have been described based on best estimates of the number of MFAS/HFAS hours that the Navy will conduct. The exact number of hours (or torpedoes, or pings, whatever unit the source is estimated in) may vary from year to year, but will not exceed the 5-year total indicated in Table 8 (by multiplying the yearly estimate by 5) by more than 10 percent. NMFS estimates that a 10-percent increase in active sonar hours (torpedoes, pings, *etc.*) would result in approximately a 10-percent increase in the number of takes, and we have considered this possibility and the effect of the additional active sonar use in our analysis.

Taking the above into account, considering the sections discussed below, and dependent upon the implementation of the proposed mitigation measures, NMFS has preliminarily determined that Navy training exercises utilizing MFAS/HFAS and underwater detonations will have a negligible impact on the marine mammal species and stocks present in the NWTRC Range Complex.

Behavioral Harassment

As discussed in the Potential Effects of Exposure of Marine Mammals to MFAS/HFAS and illustrated in the conceptual framework, marine mammals can respond to MFAS/HFAS in many different ways, a subset of which qualify as harassment (*see* Behavioral Harassment Section). One thing that the take estimates do not take into account is the fact that most marine mammals will likely avoid strong sound sources to one extent or another. Although an animal that avoids the sound source will likely still be taken in some instances (such as if the avoidance results in a missed opportunity to feed, interruption of reproductive behaviors, *etc.*) in other cases avoidance may result in fewer instances of take than were estimated or in the takes resulting from exposure to a lower received level than was estimated, which could result in a less severe response. For MFAS/HFAS, the Navy provided information (Table 9) estimating what percentage of the total takes that will occur within the 10-dB bins (without considering mitigation or avoidance) that are within the received levels considered in the risk continuum and for TTS and PTS. This table applies specifically to AN/SQS–53C hull-mounted active sonar (the most powerful source), with less powerful sources the percentages would increase slightly in the lower received levels and correspondingly decrease in the higher received levels. As mentioned above, an animal's exposure to a higher received level is more likely to result in a behavioral response that is more likely to adversely affect the health of the animal.

Received Level (SPL)	Distance At Which Levels Occur in NWTRC	Percent of Total Harassment Takes Estimated to Occur at Indicated Level
Below 140 dB	51 km - 130 km	< 1%
140 < Level < 150 dB	25 km - 51 km	2%
150 < Level < 160 dB	10 km - 25 km	18%
160 < Level < 170 dB	3 km - 10 km	43%
170 < Level < 180 dB	560 m - 3 km	28%
180 < Level	0 m - 560 m	< 9

Table 9. Approximate percent of estimated takes that occur in the indicated 10-dB bins for AN/SQS-53 (the most powerful source). For smaller sources, a higher % of the takes occur at lower levels, and a lower % at higher levels.

Because of the comparatively small amount of MFAS/HFAS sonar training the Navy has only been conducting offshore in the NWTRC, the fact that they have not been monitoring pursuant to those activities to date, and because of the overall data gap regarding the effects MFAS/HFAS has on marine mammals, not a lot is known regarding how marine mammals in the NWTRC will respond to MFAS/HFAS (with the exception of the SHOUP incident mentioned previously—but since then no sonar training has been conducted in the Inshore area). Twelve monitoring reports from the Southern California Range Complex for major training exercises indicate that watchstanders have observed no instances of obvious behavioral disturbance in the more than 704 marine mammal sightings of 7,435 animals (9,000+ hours of effort, though only 4 of the 12 reports reported the total number of hours of observation). One cannot conclude from these results that marine mammals were not harassed from MFAS/HFAS, as a portion of animals within the area of concern were not seen (especially those more cryptic, deep-diving species, such as beaked whales or *Kogia* spp.) and some of the non-biologist watchstanders might not be well-qualified to characterize behaviors. However, one can say that the animals that were observed did not respond in any of the obviously more

severe ways, such as panic, aggression, or anti-predator response.

In addition to the monitoring that will be required pursuant to these regulations and any corresponding LOAs, which is specifically designed to help us better understand how marine mammals respond to sound, the Navy and NMFS have developed, funded, and begun conducting a controlled exposure experiment with beaked whales in the Bahamas. Separately, the Navy and NMFS conducted an opportunistic tagging experiment with beaked whales in the area of the 2008 Rim of the Pacific training exercises in the HRC.

Diel Cycle

As noted previously, many animals perform vital functions, such as feeding, resting, traveling, and socializing on a diel cycle (24-hr cycle). Substantive behavioral reactions to noise exposure (such as disruption of critical life functions, displacement, or avoidance of important habitat) are more likely to be significant if they last more than one diel cycle or recur on subsequent days (Southall *et al.*, 2007). Consequently, a behavioral response lasting less than one day and not recurring on subsequent days is not considered particularly severe unless it could directly affect reproduction or survival (Southall *et al.*, 2007).

In the previous section, we discussed the fact that potential behavioral responses to MFAS/HFAS that fall into the category of harassment could range in severity. By definition, the takes by behavioral harassment involve the disturbance of a marine mammal or marine mammal stock in the wild by causing disruption of natural behavioral patterns (such as migration, surfacing, nursing, breeding, feeding, or sheltering) to a point where such behavioral patterns are abandoned or significantly altered. These reactions would, however, be more of a concern if they were expected to last over 24 hours or be repeated in subsequent days. As mentioned previously, 65 ASW exercises with a duration of 1.5 hours are planned annually for the NWTRC. Additionally, vessels with hull-mounted active sonar are typically moving at speeds of 10–12 knots, which would make it unlikely that the same animal could remain in the immediate vicinity of the ship for the entire duration of the exercise. Animals are not expected to be exposed to MFAS/HFAS at levels or for a duration likely to result in a substantive response that would then be carried on for more than one day or on successive days. With the exception of SINKEXs, the planned explosive exercises are also of a short duration (1–6 hours). Although explosive exercises may sometimes be conducted in the same general areas repeatedly, because of their short duration and the fact that they are in the open ocean and animals can easily move away makes it similarly unlikely that animals would be exposed for long, continuous amounts of time. Although SINKEXs may last for up to 48 hours, only 2 are planned annually, they are stationary and conducted in deep, open water (where fewer marine mammals would typically be expected to be randomly encountered), and they have a rigorous monitoring and shutdown protocol, all of which make it unlikely that individuals would be exposed to the exercise for extended periods or in consecutive days.

TTS

NMFS and the Navy have estimated that some individuals of some species of marine mammals may sustain some level of TTS from MFAS/HFAS. As mentioned previously, TTS can last from a few minutes to days, be of varying degree, and occur across various frequency bandwidths, all of which determine the severity of the impacts on the affected individual, which can range from minor to more severe. Table 8 indicates the estimated number of animals that might sustain TTS from exposure to MFAS/HFAS. The TTS sustained by an animal is primarily classified by three characteristics:

- *Frequency*—Available data (of mid-frequency hearing specialists exposed to mid to high frequency sounds-Southall *et al.*, 2007) suggest that most TTS occurs in the frequency range of the source up to one octave higher than the source (with the maximum TTS at ½ octave above). The more MF powerful sources used (the two hull-mounted MFAS sources and the DICASS sonobuoys) have center frequencies between 3.5 and 8 kHz and the other unidentified MF sources are, by definition, less than 10 kHz, which suggests that TTS induced by any of these MF sources would be in a frequency band somewhere between approximately 2 and 20 kHz. There are fewer hours of HF source use and the sounds would attenuate more quickly, plus they have lower source levels, but if an animal were to incur TTS from these sources, it would cover a higher frequency range (sources are between 20 and 100 kHz, which means that TTS could range up to 200 kHz, however, HF systems are typically used less frequently and for shorter time periods than surface ship and aircraft MF systems, so TTS from these sources is even less likely). TTS from explosives would be broadband. Tables 5a and 5b summarize the vocalization data for each species.
- *Degree of the shift (i.e., how many dB is the sensitivity of the hearing reduced by)*—generally, both the degree of TTS and the duration of TTS will be greater if the marine mammal is exposed to a higher level of energy (which would occur when the peak dB level is higher or the duration is longer). The threshold for the onset of TTS (> 6 dB) is 195 dB (SEL), which might be received at distances of up to 140 m from the most powerful MFAS source, the AN/SQS–53 (the maximum ranges to TTS from other sources would be less, as modeled for NWTRC). An animal would have to approach closer to the source or remain in the vicinity of the sound source appreciably longer to increase the received SEL, which would be difficult considering the watchstanders and the nominal speed of an active sonar vessel (10–12 knots). Of all TTS studies, some using exposures of almost an hour in duration or up to 217 SEL, most of the TTS induced was 15 dB or less, though Finneran *et al.*, (2007) induced 43 dB of TTS with a 64-sec exposure to a 20 kHz source (MFAS emits a 1-s ping 2 times/minute).
- *Duration of TTS (Recovery time)*—See above. Of all TTS laboratory studies, some using exposures of almost an hour in duration or up to 217 SEL, almost all recovered within 1 day (or less, often in minutes), though in one study (Finneran *et al.*, (2007)), recovery took 4 days.

Based on the range of degree and duration of TTS reportedly induced by exposures to non-pulse sounds of energy higher than that to which free-swimming marine mammals in the field are likely to be exposed during MFAS/HFAS training exercises in NWTRC, it is unlikely that marine mammals would ever sustain a TTS from MFAS that alters their sensitivity by more than 20 dB for more than a few days (and the majority would be far less severe because of short duration of the exercises, the speed of a typical vessel, and the fact that only 1 MFAS source is in use at once). Also, for the same reasons discussed in the Diel Cycle section, and because of the short distance within which animals would need to approach the sound source, it is unlikely that animals would be exposed to the levels necessary to induce TTS in subsequent time periods such that their recovery is impeded. Additionally (*see* Tables 5a and 5b), though the frequency range of TTS that marine mammals might sustain would overlap with some of the frequency ranges of their vocalization types, the frequency range of TTS from MFAS (the source from which TTS would more likely be

sustained because the higher source level and slower attenuation make it more likely that an animal would be exposed to a higher level) would not usually span the entire frequency range of one vocalization type, much less span all types of vocalizations. If impaired, marine mammals would typically be aware of their impairment and implement behaviors to compensate for it (*see* Communication Impairment Section), though these compensations may incur energetic costs.

Acoustic Masking or Communication Impairment

Table 5 is also informative regarding the nature of the masking or communication impairment that could potentially occur from MFAS (again, center frequencies are 3.5 and 7.5 kHz for the two types of hull-mounted active sonar). However, masking only occurs during the time of the signal (and potential secondary arrivals of indirect rays), versus TTS, which occurs continuously for its duration. Standard MFAS pings last on average one second and occur about once every 24–30 seconds for hull-mounted sources. For the sources for which we know the pulse length, most are significantly shorter than hull-mounted active sonar, on the order of several microseconds to 10s of microseconds. For hull-mounted active sonar, though some of the vocalizations that marine mammals make are less than one second long, there is only a 1 in 24 chance that they would occur exactly when the ping was received, and when vocalizations are longer than one second, only parts of them are masked. Alternately, when the pulses are only several microseconds long, the majority of most animals' vocalizations would not be masked. Masking effects from MFAS/HFAS are expected to be minimal. If masking or communication impairment were to occur briefly, it would be in the frequency range of MFAS, which overlaps with some marine mammal vocalizations, however, it would likely not mask the entirety of any particular vocalization or communication series because the pulse length, frequency, and duty cycle of the MFAS/HFAS signal does not perfectly mimic the characteristics of any marine mammal's vocalizations.

PTS, Injury, or Mortality

The Navy's model estimated that one Pacific harbor seal would be exposed to levels of MFAS/HFAS that would result in PTS. This estimate does not take into consideration either the mitigation measures, the likely avoidance behaviors of some of the animals exposed, the distance from the sonar dome of a surface vessel within which an animal would have to be exposed to incur PTS (10 m), and the nominal speed of a surface vessel engaged in ASW exercises. NMFS believes that many marine mammals would deliberately avoid exposing themselves to the received levels of active sonar necessary to induce injury by moving away from or at least modifying their path to avoid a close approach. Additionally, in the unlikely event that an animal approaches the sonar vessel at a close distance, NMFS believes that the mitigation measures (*i.e.*, shutdown/powerdown zones for MFAS/HFAS) would typically ensure that animals would not be exposed to injurious levels of sound. As discussed previously, the Navy utilizes both aerial (when available) and passive acoustic monitoring (during all ASW exercises) in addition to watchstanders on vessels to detect marine mammals for mitigation implementation and indicated that they are capable of effectively monitoring a 1,000-meter (1,093-yd) safety zone at night using night vision goggles, infrared cameras, and passive acoustic monitoring.

If a marine mammal is able to approach a surface vessel within the distance necessary to incur PTS, the likely speed of the vessel (nominal 10–12 knots) would make it very difficult for the animal to remain in range long enough to accumulate enough energy to result in more than a mild case of PTS. As mentioned previously and in relation to TTS, the likely consequences to the health of an individual that incurs PTS can range from mild to more serious dependent upon the degree of PTS and the frequency band it is in, and many animals are able to compensate for the shift, although it may include energetic costs. While NMFS believes it is very unlikely that a harbor seal will incur PTS from exposure to MFAS/HFAS, seals may be difficult to detect at times and the Navy has requested authorization to take one by Level A Harasssment and therefore, NMFS has considered this possibility in our analysis.

The Navy's model estimated that 14 total animals would be exposed to explosive detonations at levels that could result in injury (1 fin whale, 1 blue whale, 1 sperm whale, 3 Dall's porpoise, 1 harbor porpoise, 1 northern right whale dolphin, 2 short-beaked common dolphins, 2 northern elephant seals, 1 northern fur seal, and 1 Steller sea lion), and that 0 would be exposed to levels that would result in death—however, those estimates do not consider mitigation measures. Because of the surveillance conducted prior to and during the exercises, the associated exclusion zones (*see* table 3 and the Mitigation section), and the distance within which the animal would have to be from the explosion, NMFS does not think it likely that any animals (especially these species, which are either large individuals or large gregarious groups) will be exposed to levels of sound or pressure from explosives that will result in injury. However, an authorization for Level A take of these individuals allows the Navy to remain in compliance in the unlikely event that animals go undetected and enter an area with injurious energy or pressure levels, and therefore NMFS has considered this possibility in our analysis. Injury incurred at these levels could (based on the data the thresholds are derived from) take the form of PTS (discussed above), tympanic membrane rupture, or slight lung injury.

As discussed previously, marine mammals could potentially respond to MFAS at a received level lower than the injury threshold in a manner that indirectly results in the animals stranding. The exact mechanisms of this potential response, behavioral or physiological, are not known. The naval exercises that have been associated with strandings in the past have typically had three or more vessels operating simultaneously, or in conjunction with one another, whereas the ASW exercises in the NWTRC only utilize one surface vessel sonar source at a time. Also, past sonar-associated strandings have involved constricted channels, semi-enclosed areas, and/or steep bathymetry—the sorts of features present in the Inshore area of the NWTRC; however, no ASW exercises will be conducted in the Inshore area. Last, even if the physical features that may contribute to a stranding (not all of which are known) were present in the NWTRC, it is unlikely that they would co-occur in time and space given the nature of the exercises, *e.g.,* low number and short duration of the planned exercises and no multi-vessel ASW exercises over an extended period of time.

60 Years of Navy Training Exercises Using MFAS/HFAS in the NWTRC Range Complex

The Navy has been conducting MFAS/HFAS training exercises in the NWTRC Range Complex for over 60 years. Although monitoring specifically in conjunction with training exercises to determine the effects of active sonar and explosives on marine mammals has not been conducted by the Navy in the past

in the NWTRC and the symptoms indicative of potential acoustic trauma were not as well recognized prior to the mid-nineties, people have been collecting stranding data in the NWTRC Range Complex for approximately 30 years. Though not all dead or injured animals are expected to end up on the shore (some may be eaten or float out to sea), one might expect that if marine mammals were being harmed by the Navy training exercises with any regularity, more evidence would have been detected over the 30-yr period.

Species-Specific Analysis

In the discussions below, the ''acoustic analysis'' refers to the Navy's analysis, which includes the use of several models and other applicable calculations as described in the Estimates of Potential Marine Mammal Exposure section. The numbers predicted by the ''acoustic analysis'' are based on a uniform and stationary distribution of marine mammals and do not take into consideration the implementation of mitigation measures or potential avoidance behaviors of marine mammals, and therefore, are likely overestimates of potential exposures to the indicated thresholds (PTS, TTS, behavioral harassments).

Blue Whale (MMPA Depleted/ESA-Listed)

Acoustic analysis predicts that 19 exposures of blue whales to MFAS/HFAS or explosive detonations at sound or pressure levels likely to result in Level B harassment will occur. This estimate represents the total number of takes and not necessarily the number of individuals taken, as a single individual may be taken multiple times over the course of a year. These Level B takes are anticipated to be primarily in the form of behavioral disturbance as described in the Definition of Harassment: Level B Harassment section, although one TTS take is estimated from explosive exposure and proposed to be authorized. It is unlikely that any blue whales will incur TTS because of: (1) The distance within which they would have to approach the explosive source; and (2) the likelihood that Navy monitors would, during pre- or during exercises monitoring, detect these large animals prior to an approach within this distance and require a delay of the exercise. Navy lookouts will likely detect a group of blue whales given their large size, average group size (2–3), and pronounced vertical blow.

Additionally, the Navy's acoustic analysis predicted that 1 blue whale would be exposed to injurious levels of energy or pressure from exposure to explosive detonations. Because of the lengthy pre-monitoring, the size of the animal, and the pronounced blow, NMFS anticipates that the Navy watchstanders would likely detect blue whales in most instances and implement the mitigation to avoid exposure at injurious levels. Although NMFS does not anticipate Level A take of this species to occur, the Navy has requested Level A take authorization for this species to ensure MMPA compliance and NMFS will analyze the possibility of these effects. NMFS is currently engaged in an internal Section 7 consultation under the ESA and the outcome of that consultation will further inform our final decision.

Blue whales in the NWTRC belong to the Eastern North Pacific stock, which may be increasing in number. The best population estimate for this stock is 1,866. Blue whales are known to feed in the southern part of the NWTRC in the summer. Relative to the population size, this activity is anticipated to result only in a limited number of level B harassment takes. The blue whale's large size and detectability makes it unlikely that these animals would be exposed to the higher energy or pressure expected to result in more severe effects either during their selected feeding times or otherwise. The NWTRC activities are not expected to occur in an area/time of specific importance for reproduction, feeding, or other known critical behaviors. Consequently, the activities are not expected to adversely impact rates of recruitment or survival of blue whales. Based on the general information contained in the Negligible Impact Analysis section and this stock-specific summary of the effects of the takes, NMFS has preliminarily determined that the Navy's specified activities will have a negligible impact on this stock.

Fin Whale (MMPA Depleted/ESA-Listed)

Acoustic analysis indicates that up to 122 exposures of fin whales to sound levels likely to result in Level B harassment (2 from TTS) may result from MFAS/HFAS. This estimate represents the total number of takes and not necessarily the number of individuals taken, as a single individual may be taken multiple times over the course of a year. These Level B takes are anticipated to primarily be in the form of behavioral harassment as described in the Definition of Harassment: Level B Harassment section. Although 2 of the modeled Level B Harassment takes were predicted to be in the form of TTS from MFAS/HFAS, NMFS believes it is unlikely that any fin whales will incur TTS because of the distance within which they would have to approach the MFAS source (approximately 140 m for the most powerful source for TTS), the fact that many animals will likely avoid active sonar sources to some degree, and the likelihood that Navy monitors would detect these animals prior to an approach within this distance and implement active sonar powerdown or shutdown. Navy lookouts will likely detect a group of fin whales because of their large size, mean group size (3), and pronounced blow.

Acoustic analysis also predicted that 19 Level B Harassment takes from explosives would occur (12 sub-TTS, 7 TTS). For the same reasons listed above, NMFS anticipates that the Navy watchstanders would likely detect these species and implement the mitigation to avoid exposure. However, the range to TTS for a few of the larger explosives is larger than the associated exclusion zones for BOMBEX or SINKEX (*see* Table 3), and therefore NMFS anticipates that TTS takes of a fin whales might result from explosive detonations.

Additionally, the Navy's acoustic analysis predicted that 1 fin whale would be exposed to injurious levels of energy or pressure. Because of the lengthy pre-monitoring, the size of the animal, and the pronounced blow, NMFS anticipates that the Navy watchstanders would likely detect fin whales in most instances and implement the mitigation to avoid exposure at injurious levels. Although NMFS does not anticipate Level A take of this species to occur, the Navy has requested Level A take authorization for this species to ensure MMPA compliance and NMFS will analyze the possibility of these effects. NMFS is currently engaged in an internal Section 7 consultation under the ESA and the outcome of that consultation will further inform our final decision.

Fin whales in the NWTRC belong to the California/Oregon/Washington stock. The best population estimate for this stock is 3454, which may be increasing. Relative to the population size, this activity is anticipated to result only in a limited number of level B harassment takes. The NWTRC activities are not expected to occur in an area/time of specific importance for reproductive, feeding, or other known critical behaviors. Consequently, the activities are not expected to adversely impact rates of recruitment or survival of fin whales. Based on the general information contained in the Negligible Impact Analysis section and this stock-specific summary of the effects of the takes, NMFS has preliminarily determined that the Navy's specified

activities will have a negligible impact on this stock.

Sei Whale (MMPA Depleted/ESA-Listed)

Acoustic analysis predicts that 1 sei whale will be behaviorally harassed by exposure to MFAS/HFAS. Sei whales in the NWTRC belong to the Eastern North Pacific stock. The best population estimate for this stock is 43, which may be increasing. The sei whales' large size and detectability makes it unlikely that these animals would be exposed to the higher energy or pressure expected to result in more severe effects. No areas of specific importance for reproduction or feeding of sei whales have been identified in the NWTRC. Relative to the population size, this activity is anticipated to result only in a limited number of level B harassment takes. The NWTRC activities are not expected to occur in an area/time of specific importance for reproductive, feeding, or other known critical behaviors. Consequently, the activities are not expected to adversely impact rates of recruitment or survival of sei whales. Based on the general information contained in the Negligible Impact Analysis section and this stock-specific summary of the effects of the takes, NMFS has preliminarily determined that the Navy's specified activities will have a negligible impact on this stock.

Humpback Whale (MMPA Depleted/ESA-Listed)

Acoustic analysis predicts that 13 humpback whales will be behaviorally harassed by exposure to MFAS/HFAS. No humpback whales are expected to be taken as a result of exposure to explosive detonations. Humpback whales in the NWTRC belong to the Eastern North Pacific stock. The best population estimate for this stock is 1396, which is increasing. The humpback whales' large size, gregarious nature, and detectability makes it unlikely that these animals would be exposed to the higher energy or pressure expected to result in more severe effects. No areas of specific importance for reproduction or feeding of humpbacks have been identified in the NWTRC. Relative to the population size, this activity is anticipated to result only in a limited number of level B harassment takes. The NWTRC activities are not expected to occur in an area/time of specific importance for reproductive, feeding, or other known critical behaviors. Consequently, the activities are not expected to adversely impact rates of recruitment or survival of humpback whales. Based on the general information contained in the Negligible Impact Analysis section and this stock-specific summary of the effects of the takes, NMFS has preliminarily determined that the Navy's specified activities will have a negligible impact on this stock.

Gray Whale

Acoustic analysis predicts that 4 gray whales will be behaviorally harassed by exposure to MFAS/HFAS. No gray whales are expected to be taken as a result of exposure to explosive detonations. Gray whales in the NWTRC belong to the Eastern North Pacific stock, which is increasing in number. The best population estimate for this stock is 18178. The gray whales' large size and detectability makes it unlikely that these animals would be exposed to the higher energy or pressure expected to result in more severe effects. There is a well-defined north-south migratory path through the NWTRC and a known aggregation of gray whales (Pacific Coast Feeding Aggregation (PCFA)) that feeds along the Pacific coast between southeastern Alaska and southern California throughout the summer and fall. Relative to the population size, however, this activity is anticipated to result only in a very limited number of level B harassment takes and, consequently, the activities are not expected to adversely impact rates of recruitment or survival of gray whales. Based on the general information contained in the Negligible Impact Analysis section and this stock-specific summary of the effects of the takes, NMFS has preliminarily determined that the Navy's specified activities will have a negligible impact on this stock.

Minke Whale

Acoustic analysis predicts that 9 minke whales will be behaviorally harassed by exposure to MFAS/HFAS. No minke whales are expected to be taken as a result of exposure to explosive detonations. Minke whales in the NWTRC belong to the California/Oregon/Washington stock. The best population estimate for this stock is 898. The whales' size and detectability makes it unlikely that these animals would be exposed to the higher energy or pressure expected to result in more severe effects. Minke whales appear to establish home ranges in the Inshore Area and have been documented feeding in several areas within the Inshore Areas, however, no activities expected to result in the take of marine mammals will occur in the Inshore Area, so these behaviors should not be negatively impacted in that area. Relative to the population size, this activity is anticipated to result only in a limited number of level B harassment takes. The NWTRC activities are not expected to occur in an area/time of specific importance for reproductive, feeding, or other known critical behaviors. Consequently, the activities are not expected to adversely impact rates of recruitment or survival of minke whales. Based on the general information contained in the Negligible Impact Analysis section and this stock-specific summary of the effects of the takes, NMFS has preliminarily determined that the Navy's specified activities will have a negligible impact on this stock.

Sperm Whale (MMPA Depleted/ESA-Listed)

Acoustic analysis predicts that up to 101 exposures of sperm whales to MFAS/HFAS at energy levels likely to result in Level B harassment may occur. This estimate represents the total number of Level B takes and not necessarily the number of individuals taken, as a single individual may be taken multiple times over the course of a year. These Level B takes are anticipated to primarily be in the form of behavioral disturbance as described in the Definition of Harassment: Level B Harassment section. Two of the modeled Level B Harassment takes were predicted to be in the form of TTS.

As indicated in Table 5, some (but not all) sperm whale vocalizations might overlap with the MFAS/HFAS TTS frequency range (2–20 kHz), which could potentially temporarily decrease an animal's sensitivity to the calls of conspecifics or returning echolocation signals. However, as noted previously, NMFS does not anticipate TTS of a long duration or severe degree to occur as a result of exposure to MFAS/HFAS. No sperm whales are predicted to be exposed to MFAS/HFAS sound levels associated with PTS or injury.

Acoustic analysis also predicted that 23 sperm whales would be exposed to sound or pressure from explosives at levels expected to result in Level B Harassment (10 from TTS). Additionally, the Navy's acoustic analysis predicted that 1 whale would be exposed to injurious levels of energy or pressure. Because of the lengthy pre-monitoring and the size of the animal, NMFS anticipates that the Navy watchstanders would likely detect sperm whales in most instances and implement the mitigation measures to avoid exposure at injurious levels. Although NMFS does not anticipate sperm whales to experience Level A Harassment, the Navy has requested Level A take authorization for this species to ensure MMPA compliance in the unlikely event that an animal is

exposed to injurious pressures from an explosive detonation and NMFS has analyzed the possibility of these effects. NMFS is currently engaged in an internal Section 7 consultation under the ESA and the outcome of that consultation will further inform our final decision. No areas of specific importance for reproduction or feeding of sperm whales have been identified in the NWTRC.

Relative to the population size, this activity is anticipated to result only in a limited number of Level B harassment takes. Additionally, the NWTRC activities are not expected to occur in an area/time of specific importance for reproductive, feeding, or other known critical behaviors. Consequently, the activities are not expected to adversely impact rates of recruitment or survival of sperm whales. Based on the general information contained in the Negligible Impact Analysis section and this stock-specific summary of the effects of the takes, NMFS has preliminarily determined that the Navy's specified activities will have a negligible impact on this stock.

Killer Whale (Southern Resident Is MMPA Depleted/ESA-Listed)

Due to the difficulty in determining particular stocks of killer whales in the wild, all stocks of killer whales were combined for modeling exposures, and therefore the modeled takes could be applied to any combination of the three stocks. When observed offshore, the determination of a particular whale to either a transient, offshore, or a resident is often difficult. For this reason, all killer whales are considered to be part of the southern resident stock for analysis of effect. The southern resident stock of killer whales is depleted under the MMPA and listed under the ESA.

Acoustic analysis predicts that 13 killer whales will be behaviorally harassed by exposure to MFAS/HFAS. The best population estimate for the southern resident killer whale stock is 89. There was an increase in the overall population from 2002–2007, however the population declined in 2008 with 85 southern resident killer whales counted. Two additional whales have been reported missing since the 2008 census count. The whale's size and detectability makes it unlikely that these animals would be exposed to the higher energy or pressure expected to result in more severe effects. As mentioned previously, there is designated critical habitat for southern resident killer whales in the Inshore Area; however, no sonar exercises and 4 very small detonations (2.5-lb), which are not expected to result in the take of marine mammals, are planned to occur in the Inshore area annually. Southern resident killer whales spend the majority of their time in the Inshore Area from May/June through October/November, although they do make multi-day trips to the outer coast. Alternately, all of the Navy's sonar use is in the Offshore Area, occurring uniformly throughout the year.

Of note, the vocalizations of killer whales fall directly into the frequency range in which TTS would be incurred from the MFAS sources used in NWTRC for ASW exercises, so it is fortunate that the Navy is conducting limited ASW exercises in the NWTRC and that killer whales are predominantly situated in the Inshore area when ASW exercises are being conducted. Killer whales produce a wide-variety of clicks and whistles, but most social sounds are pulsed, with frequencies ranging from 0.5 to 25 kHz (dominant frequency range: 1 to 6 kHz) (Thomson and Richardson, 1995). Echolocation clicks indicate source levels ranging from 195 to 224 dB re 1 µPa-m peak-to-peak, dominant frequencies ranging from 20 to 60 kHz, and durations of about 0.1 sec (Au *et al.*, 2004). Source levels associated with social sounds have been calculated to range from 131 to 168 dB re 1 µPa-m and vary with vocalization type (Veirs, 2004).

Southern resident killer whales are very vocal, making calls during all types of behavioral states. Acoustic studies of resident killer whales in the Pacific Northwest have found that there are dialects in their highly stereotyped, repetitive discrete calls, which are group-specific and shared by all group members (Ford, 1991, 2002b). These dialects likely are used to maintain group identity and cohesion, and may serve as indicators of relatedness that help prevent inbreeding between closely related whales (Ford, 1991, 2002b). Dialects have been documented in northern Norway (Ford, 2002a) and southern Alaska killer whales populations (Yurk *et al.*, 2002) and likely occur in other regions.

Both behavioral and auditory brainstem response techniques indicate killer whales can hear a frequency range of 1 to 100 kHz and are most sensitive at 20 kHz. This is one the lowest maximum-sensitivity frequencies known among toothed whales (Szymanski *et al.*, 1999).

Population estimates for the Offshore and Transient killer whale stocks are 422 and 346, respectively. Relative to the population size, this activity is anticipated to result only in a limited number of level B harassment takes. The NWTRC activities are not expected to occur in an area/time of specific importance for reproductive, feeding, or other known critical behaviors. Consequently, the activities are not expected to adversely impact rates of recruitment or survival of killer whales. Based on the general information contained in the Negligible Impact Analysis section and this stock-specific summary of the effects of the takes, NMFS has preliminarily determined that the Navy's specified activities will have a negligible impact on these stocks.

Pygmy and Dwarf Sperm Whale

Acoustic analysis predicts that 4 pygmy or dwarf sperm whales will be behaviorally harassed by exposure to MFAS/HFAS or explosives. Dwarf and pygmy sperm whales in the NWTRC belong to the California/Oregon/Washington stocks. There are no population estimates for these stocks, however, this activity is anticipated to result only in a very limited number of level B harassment takes. The NWTRC activities are not expected to occur in an area/time of specific importance for reproductive, feeding, or other known critical behaviors. Consequently, the activities are not expected to adversely impact rates of recruitment or survival of pygmy and dwarf sperm whales. Based on the general information contained in the Negligible Impact Analysis section and this stock-specific summary of the effects of the takes, NMFS has preliminarily determined that the Navy's specified activities will have a negligible impact on this stock.

Beaked Whales

Acoustic analysis predicts that 12 Baird's beaked whales, 14 Cuvier's beaked whales, and 14 Mesoplodont sp. will be taken by Level B harassment by exposure to MFAS/HFAS or explosives (1, 2, and 1 take each from explosives, relatively). Beaked whales in the NWTRC belong to the California/Oregon/Washington stocks. Census data and life history are too limited to suggest a population trend for individual species of Mesoplodont whales. Until better methods are developed for distinguishing the different mesoplodont species from one another, the management unit is defined to include all mesoplodont populations. The best population estimate for these stocks is 313, 2171, and 1024, respectively. Although no areas of specific importance for reproduction or feeding of beaked whales have been identified in the NWTRC, beaked whales are generally found in deep waters over the continental slope, oceanic seamounts, and areas with submarine escarpments (very seldom

over the continental shelf). Relative to the population size, this activity is anticipated to result only in a limited number of level B harassment takes. Consequently, the activities are not expected to adversely impact rates of recruitment or survival of beaked whales. Based on the general information contained in the Negligible Impact Analysis section and this stock-specific summary of the effects of the takes, NMFS has preliminarily determined that the Navy's specified activities will have a negligible impact on these stocks.

Short-Finned Pilot Whale

Acoustic analysis predicts that 2 pilot whales will be behaviorally harassed by exposure to MFAS/HFAS or explosives. Pilot whales are rare in the NWTRC and belong to the California/Oregon/Washington stocks. The best population estimate for these stocks is 245. Relative to the population size, this activity is anticipated to result only in a limited number of level B harassment takes. The NWTRC activities are not expected to occur in an area/time of specific importance for reproductive, feeding, or other known critical behaviors. Consequently, the activities are not expected to adversely impact rates of recruitment or survival of short-finned pilot whales. Based on the general information contained in the Negligible Impact Analysis section and this stock-specific summary of the effects of the takes, NMFS has preliminarily determined that the Navy's specified activities will have a negligible impact on these stocks.

Dolphins and Porpoises

The acoustic analysis predicts that the following numbers of Level B behavioral harassments of the associated species will occur: 4725 Dall's Porpoises, 119162 harbor porpoises, 1256 short-beaked common dolphin, 1256 short-beaked common dolphin, 734 northern right whale dolphin, 555 Pacific white-sided dolphin, and 40 striped dolphin. This estimate represents the total number of exposures and not necessarily the number of individuals exposed, as a single individual may be exposed multiple times over the course of a year. No bottlenose dolphins are expected to be taken based on the Navy's acoustic analysis.

Although a portion (147 Dall's Porpoises, 45 harbor porpoises, 42 short-beaked common dolphin,18 northern right whale dolphin, 23 Pacific white-sided dolphin, and 1 striped dolphin) of the modeled Level B Harassment takes for all of these species is predicted to be in the form of TTS from MFAS, NMFS believes it is unlikely that all of the individuals estimated will incur TTS because of the distance within which they would have to approach the active sonar source (approximately 140 m for the most powerful source), the fact that many animals will likely avoid active sonar sources to some degree, and the likelihood that Navy monitors would detect these animals prior to an approach within this distance and implement active sonar powerdown or shutdown. Navy lookouts will likely detect a group of dolphins given their relatively short dives, gregarious behavior, and large average group size. However, the Navy's proposed mitigation has a provision that allows the Navy to continue operation of MFAS if the animals are clearly bow-riding even after the Navy has initially maneuvered to try and avoid closing with the animals. Since these animals sometimes bow-ride they could potentially be exposed to levels associated with TTS as they approach or depart from bow-riding. As mentioned above and indicated in Table 5, some dolphin vocalizations might overlap with the MFAS/HFAS TTS frequency range (2–20 kHz), which could potentially temporarily decrease an animal's sensitivity to the calls of conspecifics or returning echolocation signals. However, as noted previously, NMFS does not anticipate TTS of a long duration or severe degree to occur as a result of exposure to MFAS/HFAS.

Acoustic analysis also predicted that 58 Dall's Porpoises, 5 harbor porpoises, 23 short-beaked common dolphin, 7 northern right whale dolphin, 3 Pacific white-sided dolphin, and 1 striped dolphin would be exposed to sound or pressure from explosives at levels expected to result in TTS. For the same reasons noted above, NMFS anticipates that the Navy watchstanders would likely detect these species and implement the mitigation to avoid exposure. However, the range to TTS for a few of the larger explosives is larger than the associated exclusion zones for BOMBEX, MISSILEX, or SINKEX (*see* Table 3), and therefore NMFS anticipates that TTS might not be entirely avoided during those exercises.

Acoustic analysis also predicted that 3 Dall's porpoise, a harbor porpoise, 2 short-beaked dolphin, and one northern right whale dolphin might be exposed to sound or pressure from explosive detonations that would result in PTS or injury. For the same reasons listed above (group size, dive and social behavior), NMFS anticipates that the Navy watchstanders would detect these species and implement the mitigation measures to avoid exposure. In the case of all explosive exercises, the exclusion zones are 2–12 times larger than the estimated distance at which an animal would be exposed to injurious sounds or pressure waves.

No areas of specific importance for reproduction or feeding for dolphins have been identified in the NWTRC. Table 4 shows the estimated abundance of the affected stocks of dolphins and porpoise.

Of note, the number of harbor porpoises behaviorally harassed by exposure to MFAS/HFAS is higher than the other species (and, in fact, suggests that every member of the stock could potentially be taken by Level B harassment multiple times) because of the low Level B Harassment threshold, which essentially makes the ensonified area of effects significantly larger than for the other species. However, the fact that the threshold is a step function and not a curve (and assuming uniform density) means that the vast majority of the takes occur in the very lowest levels that exceed the threshold (approximately 80% of the takes are from exposures to 120 dB to 126 dB, and then approximately 80% of those takes are in the 126 dB to 132 dB range, *etc.*), which means that the anticipated effects are not expected to be severe.

Based on the general information contained in the Negligible Impact Analysis section and this stock-specific summary of the effects of the takes, NMFS has preliminarily determined that the Navy's specified activities will have a negligible impact on these stocks.

Pinnipeds

The Navy's acoustic analysis predicts that the following numbers of Level B harassments (from exposure to MFAS/HFAS or explosives) of the associated species will occur: 120 Steller sea lion, 1,365 Northern fur seal, 286 California sea lion, 378 northern elephant seals, and 586 Pacific harbor seal. This estimate represents the total number of exposures and not necessarily the number of individuals exposed, as a single individual may be exposed multiple times over the course of a year.

The model further predicted that of those Level B harassments listed above, 290 Pacific harbor seals and 1 northern fur seal, of the modeled Level B Harassment takes for all of these species were predicted to be in the form of TTS from MFAS exposure. NMFS believes it unlikely that northern fur seals, for which the TTS threshold is 206 dB SEL, will incur TTS because of the distance within which they would have to approach the MFAS source (approximately 37 m for the most

powerful source), the fact that many animals will likely avoid active sonar sources to some degree, and the likelihood that Navy monitors would detect these pinnipeds (because of the relatively short duration of their dives and their tendency to rest near the surface) prior to an approach within this distance and implement active sonar powerdown or shutdown. For harbor seals, more animals will be exposed to levels associated with TTS because of the lower threshold (183 SEL) that can be heard approximately 1,400 m from the highest powered AN/SQS–53C source. As mentioned above and indicated in Table 5, some pinniped vocalizations might overlap with the MFAS/HFAS TTS frequency range (2–20 kHz), which could potentially temporarily decrease an animal's sensitivity to the calls of conspecifics or returning echolocation signals. However, as noted previously, NMFS does not anticipate TTS of a long duration or severe degree to occur as a result of exposure to MFAS/HFAS.

The acoustic analysis also predicted that 1 Pacific harbor seal would be exposed to MFAS/HFAS sound levels that would result in Level A Harassment (PTS—injury). However, because of the distance within which they would have to approach the MFAS source (approximately 50 m for the most powerful source) and the fact that animals will likely avoid active sonar sources to some degree, NMFS does not believe that any animals will incur PTS or be otherwise injured by MFAS/HFAS. However, the Navy has requested authorization for one Level A take for Pacific harbor seals, so NMFS is considering it in our analysis.

Acoustic analysis also predicted that of the total level B harassment takes listed in the first paragraph, 44 Northern fur seals, 1 California sea lion, and 29 northern elephant seals would be exposed to sound or pressure from explosives at levels expected to result in TTS. For the same reasons listed above, NMFS anticipates that the Navy watchstanders would likely detect the majority of the individual northern elephant seals, northern fur seals, and California sea lions and implement the mitigation measures to avoid exposure. However, the range to TTS for a few of the larger explosives is larger than the associated exclusion zones for BOMBEX, MISSILEX, or SINKEX (*see* Table 3), therefore NMFS anticipates that some TTS might not be avoided during those exercises. Acoustic analysis also predicted that 2 northern elephant seals and 1 northern fur seal might be exposed to levels of sound or pressure from explosives that would result in PTS or other injury. NMFS anticipates that the Navy watchstanders would likely detect these species and implement the mitigation measures to avoid exposure. In the case of all explosive exercises, the exclusion zones are 2–12 times larger than the estimated distance at which an animal would be exposed to injurious sounds or pressure waves. However, an authorization for Level A take of these individuals allows the Navy to remain in compliance in the unlikely event that animals go undetected and enter an area with injurious energy or pressure levels, and therefore NMFS considers it in our analysis.

Steller sea lions are MMPA depleted and ESA-listed with a decreasing population and they have designated critical habitat within the NWTRC. A small number, compared to the population estimate, are predicted to be taken by behavioral disturbance, and one potentially by injury, although NMFS does not anticipate this. Of note, the critical habitat (3 haulouts) has limitations for air approach distances and by sea approach distances and the Navy abides by these restrictions.

Generally speaking, pinniped stocks in the NWTRC are thought to be stable or increasing. Based on the general information contained in the Negligible Impact Analysis section and this stock-specific summary of the effects of the takes, NMFS has preliminarily determined that the Navy's specified activities will have a negligible impact on these stocks.

Preliminary Determination

Negligible Impact

Based on the analysis contained herein of the likely effects of the specified activity on marine mammals and their habitat and dependent upon the implementation of the mitigation and monitoring measures, NMFS preliminarily finds that the total taking from Navy training exercises utilizing MFAS/HFAS and underwater explosives in the NWTRC will have a negligible impact on the affected species or stocks. NMFS has proposed regulations for these exercises that prescribe the means of effecting the least practicable adverse impact on marine mammals and their habitat and set forth requirements pertaining to the monitoring and reporting of that taking.

Subsistence Harvest of Marine Mammals

NMFS has preliminarily determined that the issuance of 5-year regulations and subsequent LOAs for Navy training exercises in the NWTRC would not have an unmitigable adverse impact on the availability of the affected species or stocks for subsistence use for any Alaska Natives or Tribal member in the Northwest (*e.g.*, Oregon, Washington, and northern California). Specifically, the Navy's exercises would not affect any Alaskan Native because the activities will be limited to waters off the coast of Washington, Oregon, and northern California, areas outside of traditional Alaskan Native hunting grounds. Moreover, there are no cooperative agreements in force under the MMPA or Whaling Convention Act that would allow for the subsistence harvest of marine mammals in waters off the Northwest coast. Consequently, this action would not result in an unmitigable adverse impact on the availability of the affected species or stocks for taking for subsistence uses in the Northwest.

As noted above, NMFS will consider all comments, suggestions and/or concerns submitted by the public during the proposed rulemaking comment period to help inform our final decision, particularly with respect to our negligible impact determination and the proposed mitigation and monitoring measures.

ESA

There are seven marine mammal species and one sea turtle species that are listed as endangered under the ESA with confirmed or possible occurrence in the study area: Humpback whale, sei whale, fin whale, blue whale, sperm whale, southern resident killer whale, Steller sea lion, and the leatherback sea turtle. The Navy has begun consultation with NMFS pursuant to section 7 of the ESA, and NMFS will also consult internally on the issuance of an LOA under section 101(a)(5)(A) of the MMPA for NWTRC activities. Consultation will be concluded prior to a determination on the issuance of the final rule and an LOA.

NEPA

NMFS has participated as a cooperating agency on the Navy's Draft Environmental Impact Statement (DEIS) for the NWTRC, which was published on December 29, 2008. The Navy's DEIS is posted on NMFS' Web site: *http://www.nmfs.noaa.gov/pr/permits/incidental.htm#applications.* NMFS intends to adopt the Navy's Final EIS (FEIS), if adequate and appropriate. Currently, we believe that the adoption of the Navy's FEIS will allow NMFS to meet its responsibilities under NEPA for the issuance of an LOA for NWTRC. If the Navy's FEIS is deemed not to be adequate, NMFS would supplement the

existing analysis to ensure that we comply with NEPA prior to the issuance of the final rule or LOA.

Classification

This action does not contain any collection of information requirements for purposes of the Paperwork Reduction Act.

The Office of Management and Budget has determined that this proposed rule is not significant for purposes of Executive Order 12866.

Pursuant to the Regulatory Flexibility Act, the Chief Counsel for Regulation of the Department of Commerce has certified to the Chief Counsel for Advocacy of the Small Business Administration that this proposed rule, if adopted, would not have a significant economic impact on a substantial number of small entities. The Regulatory Flexibility Act requires Federal agencies to prepare an analysis of a rule's impact on small entities whenever the agency is required to publish a notice of proposed rulemaking. However, a Federal agency may certify, pursuant to 5 U.S.C. 605(b), that the action will not have a significant economic impact on a substantial number of small entities. The Navy is the sole entity that will be affected by this rulemaking, not a small governmental jurisdiction, small organization or small business, as defined by the Regulatory Flexibility Act (RFA). Any requirements imposed by a Letter of Authorization issued pursuant to these regulations, and any monitoring or reporting requirements imposed by these regulations, will be applicable only to the Navy. NMFS does not expect the issuance of these regulations or the associated LOAs to result in any impacts to small entities pursuant to the RFA. Because this action, if adopted, would directly affect the Navy and not a small entity, NMFS concludes the action would not result in a significant economic impact on a substantial number of small entities.

Dated: July 2, 2009.

James Balsiger,

Acting Assistant Administrator for Fisheries, National Marine Fisheries Service.

For reasons set forth in the preamble, 50 CFR part 218 is proposed to be amended as follows:

PART 218—REGULATIONS GOVERNING THE TAKING AND IMPORTING OF MARINE MAMMALS

1. The authority citation for part 218 continues to read as follows:

Authority: 16 U.S.C. 1361 *et seq.*

2. Subpart M is added to part 218 to read as follows:

Subpart M—Taking and Importing Marine Mammals; U.S. Navy's Northwest Training Range Complex (NWTRC)

Sec.

Subpart M—Taking and Importing Marine Mammals; U.S. Navy's Northwest Training Range Complex (NWTRC)

§ 218.110 Specified activity and specified geographical area.

(a) Regulations in this subpart apply only to the U.S. Navy for the taking of marine mammals that occurs in the area outlined in paragraph (b) of this section and that occur incidental to the activities described in paragraph (c) of this section.

(b) The taking of marine mammals by the Navy is only authorized if it occurs within the Offshore area of the Northwest Training Range Complex (NWTRC) (as depicted in Figure ES–1 in the Navy's Draft Environmental Impact Statement for NWTRC), which is bounded by 48°30′ N. lat.; 130°00′ W. long.; 40°00′ N. lat.; and on the east by 124°00′ W. long or by the shoreline where the shoreline extends west of 124°00′ W. long (excluding the Strait of Juan de Fuca (east of 124°40′ W. long), which is not included in the Offshore area).

(c) The taking of marine mammals by the Navy is only authorized if it occurs incidental to the following activities within the designated amounts of use:

(1) The use of the following mid-frequency active sonar (MFAS) sources, high frequency active sonar (HFAS) sources for U.S. Navy anti-submarine warfare (ASW) and mine warfare (MIW) training, in the amounts and in the locations indicated below (±10%):

(i) *AN/SQS–53 (hull-mounted active sonar)*—up to 215 hours over the course of 5 years (an average of 43 hours per year);

(ii) *AN/SQS–56 (hull-mounted active sonar)*—up to 330 hours over the course of 5 years (an average of 65 hours per year);

(iii) *SSQ–62 (Directional Command Activated Sonobuoy System (DICASS) sonobuoys)*—up to 4430 sonobuoys over the course of 5 years (an average of 886 sonobuoys per year)

(iv) *MK–48 (heavyweight torpedoes)*—up to 10 torpedoes over the course of 5 years (an average of 2 torpedoes per year);

(v) *AN/BQS–15 (mine detection and submarine navigational sonar)*—up to 210 hours over the course of 5 years (an average of 42 hours per year);

(vi) *AN/SSQ–125 (AEER)*—up to 745 buoys deployed over the course of 5 years (total combined with the AN/SSQ–110A (IEER)) (an average of 149 per year);

(vii) *Range Pingers*—up to 900 hours over the course of 5 years (an average of 180 hours per year); and

(viii) *PUTR Uplink*—up to 750 hours over the course of 5 years (an average of 150 hours per year).

(2) The detonation of the underwater explosives indicated in this paragraph (c)(2)(i) conducted as part of the training events indicated in this paragraph (c)(2)(ii):

(i) Underwater Explosives

(A) 5″ Naval Gunfire (9.5 lbs);
(B) 76 mm rounds (1.6 lbs);
(C) Maverick (78.5 lbs);
(D) Harpoon (448 lbs);
(E) MK–82 (238 lbs);
(F) MK–48 (851 lbs);
(G) Demolition Charges (2.5 lbs);
(H) AN/SSQ–110A (IEER explosive sonobuoy—5 lbs);
(I) HARM;
(J) Hellfire;
(K) SLAM; and
(L) GBU 10, 12, and 16.

(ii) Training Events

(A) *Surface-to-surface Gunnery Exercises (S–S GUNEX)*—up to 1700 exercises over the course of 5 years (an average of 340 per year).

(B) *Bombing Exercises (BOMBEX)*—up to 150 exercises over the course of 5 years (an average of 30 per year).

(C) *Sinking Exercises (SINKEX)*—up to 10 exercises over the course of 5 years (an average of 2 per year).

(D) *Extended Echo Ranging and Improved Extended Echo Ranging (EER/IEER) Systems*—up to 60 exercises (total combined with the AN/SSQ–125A (AEER)) over the course of 5 years (an average of 12 per year).

§ 218.111 [Reserved]

§ 218.112 Permissible methods of taking.

(a) Under Letters of Authorization issued pursuant to §§ 216.106 and 218.117 of this chapter, the Holder of

the Letter of Authorization (hereinafter ''Navy'') may incidentally, but not intentionally, take marine mammals within the area described in § 218.110(b), provided the activity is in compliance with all terms, conditions, and requirements of these regulations and the appropriate Letter of Authorization.

(b) The activities identified in § 218.110(c) must be conducted in a manner that minimizes, to the greatest extent practicable, any adverse impacts on marine mammals and their habitat.

(c) The incidental take of marine mammals under the activities identified in § 218.110(c) is limited to the following species, by the indicated method of take and the indicated number of times (estimated based on the authorized amounts of sound source operation):

(1) Level B Harassment (±10% of the Take Estimate Indicated Below)

(i) Mysticetes

(A) *Humpback whale (Megaptera novaeangliae)*—75 (an average of 15 annually);

(B) *Fin whale (Balaenoptera physalus)*—720 (an average of 144 annually);

(C) *Blue whale (Balaenoptera musculus)*—95 (an average of 19 annually);

(D) *Sei whale (Balaenoptera borealis)*—5 (an average of 1 annually);

(E) *Minke whale (Balaenoptera acutorostrata)*—45 (an average of 9 annually); and

(F) *Gray whale (Eschrichtius robustus)*—20 (an average of 4 annually).

(ii) Odontocetes

(A) *Sperm whales (Physeter macrocephalus)*—635 (an average of 127 annually);

(B) *Killer whale (Orcinus orca)*—70 (an average of 14 annually);

(C) *Pygmy or dwarf sperm whales (Kogia breviceps or Kogia sima)*—20 (an average of 94 annually);

(D) *Mesoplodont beaked whales*—75 (an average of 15 annually);

(E) *Cuvier's beaked whales (Ziphius cavirostris)*—70 (an average of 14 annually);

(F) *Baird's beaked whales (Berardius bairdii)*—65 (an average of 13 annually);

(G) *Short-finned pilot whale (Globicephala macrorynchus)*—10 (an average of 2 annually);

(H) *Striped dolphin (Stenella coeruleoalba)*—400 (an average of 40 annually);

(I) *Short-beaked common dolphin (Globicephala macrorhynchus)*—6280 (an average of 1256 annually);

(J) *Risso's dolphin (Grampus griseus)*—500 (an average of 100 annually);

(K) *Northern right whale dolphin (Lissodelphis borealis)*—3705 (an average of 741 annually);

(L) *Pacific white-sided dolphin (Lagenorhynchus obliquidens)*—2855 (an average of 571 annually);

(M) *Dall's porpoise (Phocoenoides dalli)*—23780 (an average of 4752 annually); and

(N) *Harbor Porpoise (Phocoena phocoena)*—596370 (an average of 119274 annually).

(ii) Pinnipeds

(A) *Northern elephant seal (Mirounga angustirostris)*—1890 (an average of 378 annually);

(B) *Pacific harbor seal (Phoca vitulina)*—2930 (an average of 586 annually);

(C) *California sea lion (Zalophus californianus)*—1430 (an average of 286 annually);

(D) *Northern fur seal (Callorhinus ursinus)*—6825 (an average of 1365 annually); and

(E) *Steller sea lion (Eumetopias jubatus)*—600 (an average of 120 annually).

(2) Level A Harassment

(i) *Fin whale*—5 (an average of 1 annually);

(ii) *Blue Whale*—5 (an average of 1 annually);

(iii) *Sperm whale*—5 (an average of 1 annually);

(iv) *Dall's Porpoise*—15 (an average of 3 annually);

(v) *Harbor Porpoise*—5 (an average of 1 annually);

(vi) *Northern right whale dolphin*—5 (an average of 1 annually);

(vii) *Short-beaked common dolphin*—10 (an average of 2 annually);

(viii) *Northern elephant seal*—10 (an average of 2 annually);

(ix) *Pacific harbor seal*—5 (an average of 1 annually); and

(x) *Northern fur seal*—5 (an average of 1 annually).

§ 218.113 Prohibitions.

No person in connection with the activities described in § 218.110 may:

(a) Take any marine mammal not specified in § 218.112(c);

(b) Take any marine mammal specified in § 218.112(c) other than by incidental take as specified in §§ 218.112(c)(1) and (c)(2);

(c) Take a marine mammal specified in § 218.112(c) if such taking results in more than a negligible impact on the species or stocks of such marine mammal; or

(d) Violate, or fail to comply with, the terms, conditions, and requirements of these regulations or a Letter of Authorization issued under §§ 216.106 and 218.117 of this chapter.

§ 218.114 Mitigation.

(a) When conducting training and utilizing the sound sources or explosives identified in § 218.110(c), the mitigation measures contained in the Letter of Authorization issued under §§ 216.106 and 218.117 of this chapter must be implemented. These mitigation measures include, but are not limited to:

(1) Navy's General Maritime Measures for All Training at Sea

(i) Personnel Training (for All Training Types)

(A) All commanding officers (COs), executive officers (XOs), lookouts, Officers of the Deck (OODs), junior OODs (JOODs), maritime patrol aircraft aircrews, and Anti-submarine Warfare (ASW)/Mine Warfare (MIW) helicopter crews shall complete the NMFS-approved Marine Species Awareness Training (MSAT) by viewing the U.S. Navy MSAT digital versatile disk (DVD). All bridge lookouts shall complete both parts one and two of the MSAT; part two is optional for other personnel.

(B) Navy lookouts shall undertake extensive training in order to qualify as a watchstander in accordance with the Lookout Training Handbook (Naval Education and Training Command [NAVEDTRA] 12968–D).

(C) Lookout training shall include on-the-job instruction under the supervision of a qualified, experienced lookout. Following successful completion of this supervised training period, lookouts shall complete the Personal Qualification Standard Program, certifying that they have demonstrated the necessary skills (such as detection and reporting of partially submerged objects). Personnel being trained as lookouts can be counted among required lookouts as long as supervisors monitor their progress and performance.

(D) Lookouts shall be trained in the most effective means to ensure quick and effective communication within the command structure in order to facilitate implementation of protective measures if marine species are spotted.

(ii) Operating Procedures and Collision Avoidance

(A) Prior to major exercises, a Letter of Instruction, Mitigation Measures Message or Environmental Annex to the Operational Order shall be issued to further disseminate the personnel

training requirement and general marine species protective measures.

(B) COs shall make use of marine species detection cues and information to limit interaction with marine species to the maximum extent possible consistent with safety of the ship.

(C) While underway, surface vessels shall have at least two lookouts with binoculars; surfaced submarines shall have at least one lookout with binoculars. Lookouts already posted for safety of navigation and man-overboard precautions may be used to fill this requirement. As part of their regular duties, lookouts will watch for and report to the OOD the presence of marine mammals.

(D) On surface vessels equipped with a multi-function active sensor, pedestal mounted ''Big Eye'' (20x110) binoculars shall be properly installed and in good working order to assist in the detection of marine mammals in the vicinity of the vessel.

(E) Personnel on lookout shall employ visual search procedures employing a scanning methodology in accordance with the Lookout Training Handbook (NAVEDTRA 12968–D).

(F) After sunset and prior to sunrise, lookouts shall employ Night Lookouts Techniques in accordance with the Lookout Training Handbook. (NAVEDTRA 12968–D).

(G) While in transit, naval vessels shall be alert at all times, use extreme caution, and proceed at a ''safe speed'' so that the vessel can take proper and effective action to avoid a collision with any marine animal and can be stopped within a distance appropriate to the prevailing circumstances and conditions.

(H) When marine mammals have been sighted in the area, Navy vessels shall increase vigilance and take reasonable and practicable actions to avoid collisions and activities that might result in close interaction of naval assets and marine mammals. Actions may include changing speed and/or direction and are dictated by environmental and other conditions (*e.g.,* safety, weather).

(I) Navy aircraft participating in exercises at sea shall conduct and maintain, when operationally feasible and safe, surveillance for marine mammals as long as it does not violate safety constraints or interfere with the accomplishment of primary operational duties. Marine mammal detections shall be immediately reported to assigned Aircraft Control Unit for further dissemination to ships in the vicinity of the marine species as appropriate when it is reasonable to conclude that the course of the ship will likely result in a closing of the distance to the detected marine mammal.

(2) Navy's Measures for MFAS Operations

(i) Personnel Training (for MFAS Operations)

(A) All lookouts onboard platforms involved in ASW training events shall review the NMFS-approved Marine Species Awareness Training material prior to use of mid-frequency active sonar.

(B) All COs, XOs, and officers standing watch on the bridge shall have reviewed the Marine Species Awareness Training material prior to a training event employing the use of mid-frequency active sonar.

(C) Navy lookouts shall undertake extensive training in order to qualify as a watchstander in accordance with the Lookout Training Handbook (Naval Educational Training [NAVEDTRA], 12968–D).

(D) Lookout training shall include on-the-job instruction under the supervision of a qualified, experienced watchstander. Following successful completion of this supervised training period, lookouts shall complete the Personal Qualification Standard program, certifying that they have demonstrated the necessary skills (such as detection and reporting of partially submerged objects). This does not forbid personnel being trained as lookouts from being counted as those listed in previous measures so long as supervisors monitor their progress and performance.

(E) Lookouts shall be trained in the most effective means to ensure quick and effective communication within the command structure in order to facilitate implementation of mitigation measures if marine species are spotted.

(ii) Lookout and Watchstander Responsibilities

(A) On the bridge of surface ships, there shall always be at least three people on watch whose duties include observing the water surface around the vessel.

(B) All surface ships participating in ASW training events shall, in addition to the three personnel on watch noted previously, have at all times during the exercise at least two additional personnel on watch as marine mammal lookouts.

(C) After sunset and prior to sunrise, lookouts shall employ Night Lookouts Techniques in accordance with the Lookout Training Handbook.

(D) Personnel on lookout shall be responsible for reporting all objects or anomalies sighted in the water (regardless of the distance from the vessel) to the Officer of the Deck, since any object or disturbance (*e.g.,* trash, periscope, surface disturbance, discoloration) in the water may be indicative of a threat to the vessel and its crew or indicative of a marine species that may need to be avoided as warranted. Personnel on lookout and officers on watch on the bridge will have at least one set of binoculars available for each person to aid in the detection of marine mammals.

(iii) Operating Procedures (for MFAS Operations)

(A) All personnel engaged in passive acoustic sonar operation (including aircraft, surface ships, or submarines) shall monitor for marine mammal vocalizations and report the detection of any marine mammal to the appropriate watch station for dissemination and appropriate action.

(B) During mid-frequency active sonar operations, personnel shall utilize all available sensor and optical systems (such as night vision goggles) to aid in the detection of marine mammals.

(C) Navy aircraft participating in exercises at sea shall conduct and maintain, when operationally feasible and safe, surveillance for marine species of concern as long as it does not violate safety constraints or interfere with the accomplishment of primary operational duties.

(D) Aircraft with deployed sonobuoys shall use only the passive capability of sonobuoys when marine mammals are detected within 200 yds (183 m) of the sonobuoy.

(E) Marine mammal detections shall be immediately reported to assigned Aircraft Control Unit for further dissemination to ships in the vicinity of the marine species as appropriate where it is reasonable to conclude that the course of the ship will likely result in a closing of the distance to the detected marine mammal.

(F) *Safety Zones*—When marine mammals are detected by any means (aircraft, shipboard lookout, or acoustically) within or closing to inside 1,000 yds (914 m) of the sonar dome (the bow), the ship or submarine shall limit active transmission levels to at least 6 decibels (dB) below normal operating levels.

(*1*) Ships and submarines shall continue to limit maximum transmission levels by this 6-dB factor until the animal has been seen to leave the area, has not been detected for 30 minutes, or the vessel has transited more than 2,000 yds (1829 m) beyond the location of the last detection.

(*2*) Should a marine mammal be detected within or closing to inside 500 yds (457 m) of the sonar dome, active sonar transmissions shall be limited to at least 10 dB below the equipment's normal operating level. Ships and submarines shall continue to limit maximum ping levels by this 10-dB factor until the animal has been seen to leave the area, has not been detected for 30 minutes, or the vessel has transited more than 2,000 yds (1829 m) beyond the location of the last detection.

(*3*) Should the marine mammal be detected within or closing to inside 200 yds (183 m) of the sonar dome, active sonar transmissions shall cease. Sonar shall not resume until the animal has been seen to leave the area, has not been detected for 30 minutes, or the vessel has transited more than 2,000 yds (1829 m) beyond the location of the last detection.

(*4*) Special conditions applicable for dolphins and porpoises only: If, after conducting an initial maneuver to avoid close quarters with dolphins or porpoises, the OOD concludes that dolphins or porpoises are deliberately closing to ride the vessel's bow wave, no further mitigation actions are necessary while the dolphins or porpoises continue to exhibit bow wave riding behavior.

(*5*) If the need for power-down should arise as detailed in ''Safety Zones'' above, the Navy shall follow the requirements as though they were operating at 235 dB—the normal operating level (*i.e.,* the first power-down will be to 229 dB, regardless of at what level above 235 dB active sonar was being operated).

(G) Prior to start up or restart of active sonar, operators will check that the Safety Zone radius around the sound source is clear of marine mammals.

(H) *Active sonar levels (generally)*—Navy shall operate active sonar at the lowest practicable level, not to exceed 235 dB, except as required to meet tactical training objectives.

(3) Navy's Measures for Underwater Detonations

(i) Surface-to-Surface Gunnery (Non-Explosive Rounds)

(A) A 200-yd (183 m) radius buffer zone shall be established around the intended target.

(B) From the intended firing position, trained lookouts shall survey the buffer zone for marine mammals prior to commencement and during the exercise as long as practicable.

(C) If applicable, target towing vessels shall maintain a lookout. If a marine mammal is sighted in the vicinity of the exercise, the tow vessel shall immediately notify the firing vessel in order to secure gunnery firing until the area is clear.

(D) The exercise shall be conducted only when the buffer zone is visible and marine mammals are not detected within the target area and the buffer zone.

(ii) Surface-to-Air Gunnery (Explosive and Non-Explosive Rounds)

(A) Vessels shall orient the geometry of gunnery exercises in order to prevent debris from falling in the area of sighted marine mammals.

(B) Vessels will expedite the recovery of any parachute deploying aerial targets to reduce the potential for entanglement of marine mammals.

(C) Target towing aircraft shall maintain a lookout. If a marine mammal is sighted in the vicinity of the exercise, the tow aircraft shall immediately notify the firing vessel in order to secure gunnery firing until the area is clear.

(iii) Air-to-Surface At-Sea Bombing Exercises (Explosive and Non-Explosive)

(A) If surface vessels are involved, trained lookouts shall survey for floating kelp and marine mammals. Ordnance shall not be targeted to impact within 1,000 yds (914 m) of known or observed floating kelp or marine mammals.

(B) A 1,000 yd (914-m) radius buffer zone shall be established around the intended target.

(C) Aircraft shall visually survey the target and buffer zone for marine mammals prior to and during the exercise. The survey of the impact area shall be made by flying at 1,500 ft (152 m) or lower, if safe to do so, and at the slowest safe speed. Release of ordnance through cloud cover is prohibited: aircraft must be able to actually see ordnance impact areas. Survey aircraft should employ most effective search tactics and capabilities.

(D) The exercise will be conducted only if marine mammals are not visible within the buffer zone.

(iv) Air-to-Surface Missile Exercises (Explosive and Non-Explosive)

(A) Ordnance shall not be targeted to impact within 1,800 yds (1646 m) of observed floating kelp.

(B) Aircraft shall visually survey the target area for marine mammals. Visual inspection of the target area shall be made by flying at 1,500 (457 m) feet or lower, if safe to do so, and at slowest safe speed. Firing or range clearance aircraft must be able to actually see ordnance impact areas. Explosive ordnance shall not be targeted to impact within 1,800 yds (1646 m) of sighted marine mammals.

(v) Demolitions, Mine Warfare, and Mine Countermeasures (Up to a 2.5-lb Charge)

(A) *Exclusion Zones*—All Mine Warfare and Mine Countermeasures Operations involving the use of explosive charges must include exclusion zones for marine mammals to prevent physical and/or acoustic effects to those species. These exclusion zones shall extend in a 700-yard arc radius around the detonation site.

(B) *Pre-Exercise Surveys*—For Demolition and Ship Mine Countermeasures Operations, pre-exercise surveys shall be conducted within 30 minutes prior to the commencement of the scheduled explosive event. The survey may be conducted from the surface, by divers, and/or from the air, and personnel shall be alert to the presence of any marine mammal. Should such an animal be present within the survey area, the explosive event shall not be started until the animal voluntarily leaves the area. The Navy will ensure the area is clear of marine mammals for a full 30 minutes prior to initiating the explosive event. Personnel will record any marine mammal observations during the exercise as well as measures taken if species are detected within the exclusion zone.

(C) *Post-Exercise Surveys*—Surveys within the same radius shall also be conducted within 30 minutes after the completion of the explosive event.

(D) *Reporting*—If there is evidence that a marine mammal may have been stranded, injured or killed by the action, Navy training activities shall be immediately suspended and the situation immediately reported by the participating unit to the Officer in Charge of the Exercise (OCE), who will follow Navy procedures for reporting the incident to the Commander, Pacific Fleet, Commander, Navy Region Northwest, Environmental Director, and the chain of command. The situation shall also be reported to NMFS (see Stranding Plan for details).

(vi) Sink Exercise

(A) All weapons firing shall be conducted during the period 1 hour after official sunrise to 30 minutes before official sunset.

(B) An exclusion zone with a radius of 1.0 nm (1.9 km) would be established around each target. This exclusion zone is based on calculations using a 990-lb (450-kg) H6 net explosive weight high explosive source detonated 5 ft (1.5 m) below the surface of the water, which

yields a distance of 0.85 nm (1.57 km) (cold season) and 0.89 nm (1.65 km) (warm season) beyond which the received level is below the 182 decibels (dB) re: 1 micropascal squared-seconds (μPa2-s) threshold established for the WINSTON S. CHURCHILL (DDG 81) shock trials (U.S. Navy, 2001). An additional buffer of 0.5 nm (0.9 km) would be added to account for errors, target drift, and animal movements. Additionally, a safety zone, which would extend beyond the buffer zone by an additional 0.5 nm (0.9 km), would be surveyed. Together, the zones extend out 2 nm (3.7 km) from the target.

(C) A series of surveillance overflights shall be conducted within the exclusion and the safety zones, prior to and during the exercise, when feasible. Survey protocol shall be as follows:

(*1*) Overflights within the exclusion zone shall be conducted in a manner that optimizes the surface area of the water observed. This may be accomplished through the use of the Navy's Search and Rescue Tactical Aid, which provides the best search altitude, ground speed, and track spacing for the discovery of small, possibly dark objects in the water based on the environmental conditions of the day. These environmental conditions include the angle of sun inclination, amount of daylight, cloud cover, visibility, and sea state.

(*2*) All visual surveillance activities shall be conducted by Navy personnel trained in visual surveillance. At least one member of the mitigation team would have completed the Navy's marine mammal training program for lookouts.

(*3*) In addition to the overflights, the exclusion zone shall be monitored by passive acoustic means, when assets are available. This passive acoustic monitoring would be maintained throughout the exercise. Potential assets include sonobuoys, which can be utilized to detect any vocalizing marine mammals (particularly sperm whales) in the vicinity of the exercise. The sonobuoys shall be re-seeded as necessary throughout the exercise. Additionally, passive sonar onboard submarines may be utilized to detect any vocalizing marine mammals in the area. The OCE would be informed of any aural detection of marine mammals and would include this information in the determination of when it is safe to commence the exercise.

(*4*) On each day of the exercise, aerial surveillance of the exclusion and safety zones shall commence 2 hours prior to the first firing.

(*5*) The results of all visual, aerial, and acoustic searches shall be reported immediately to the OCE. No weapons launches or firing may commence until the OCE declares the safety and exclusion zones free of marine mammals.

(*6*) If a marine mammal observed within the exclusion zone is diving, firing would be delayed until the animal is re-sighted outside the exclusion zone, or 30 minutes have elapsed. After 30 minutes, if the animal has not been re-sighted it would be assumed to have left the exclusion zone. The OCE would determine if the listed species is in danger of being adversely affected by commencement of the exercise.

(*7*) During breaks in the exercise of 30 minutes or more, the exclusion zone shall again be surveyed for any marine mammal. If marine mammals are sighted within the exclusion zone, the OCE shall be notified, and the procedure described above would be followed.

(*8*) Upon sinking of the vessel, a final surveillance of the exclusion zone shall be monitored for 2 hours, or until sunset, to verify that no marine mammals were harmed.

(D) Aerial surveillance shall be conducted using helicopters or other aircraft based on necessity and availability. The Navy has several types of aircraft capable of performing this task; however, not all types are available for every exercise. For each exercise, the available asset best suited for identifying objects on and near the surface of the ocean would be used. These aircraft would be capable of flying at the slow safe speeds necessary to enable viewing of marine vertebrates with unobstructed, or minimally obstructed, downward and outward visibility. The exclusion and safety zone surveys may be cancelled in the event that a mechanical problem, emergency search and rescue, or other similar and unexpected event preempts the use of one of the aircraft onsite for the exercise.

(E) Every attempt would be made to conduct the exercise in sea states that are ideal for marine mammal sighting, Beaufort Sea State 3 or less. In the event of a 4 or above, survey efforts shall be increased within the zones. This shall be accomplished through the use of an additional aircraft, if available, and conducting tight search patterns.

(F) The exercise shall not be conducted unless the exclusion zone could be adequately monitored visually.

(G) In the event that any marine mammals are observed to be harmed in the area, a detailed description of the animal shall be taken, the location noted, and if possible, photos taken. This information shall be provided to NMFS via the Navy's regional environmental coordinator for purposes of identification (*see* the Stranding Plan for detail).

(H) An after action report detailing the exercise's time line, the time the surveys commenced and terminated, amount, and types of all ordnance expended, and the results of survey efforts for each event shall be submitted to NMFS.

(vii) Extended Echo Ranging/Improved Extended Echo Ranging (EER/IEER)

(A) Crews shall conduct visual reconnaissance of the drop area prior to laying their intended sonobuoy pattern. This search shall be conducted at an altitude below 457 m (500 yd) at a slow speed, if operationally feasible and weather conditions permit. In dual aircraft operations, crews are allowed to conduct coordinated area clearances.

(B) Crews shall conduct a minimum of 30 minutes of visual and aural monitoring of the search area prior to commanding the first post detonation. This 30-minute observation period may include pattern deployment time.

(C) For any part of the briefed pattern where a post (source/receiver sonobuoy pair) will be deployed within 914 m (1,000 yd) of observed marine mammal activity, the Navy shall deploy the receiver ONLY and monitor while conducting a visual search. When marine mammals are no longer detected within 914 m (1,000 yd) of the intended post position, the Navy shall co-locate the explosive source sonobuoy (AN/SSQ–110A) (source) with the receiver.

(D) When operationally feasible, Navy crews shall conduct continuous visual and aural monitoring of marine mammal activity. This is to include monitoring of own-aircraft sensors from first sensor placement to checking off station and out of RF range of these sensors.

(E) *Aural Detection*—If the presence of marine mammals is detected aurally, then that shall cue the Navy aircrew to increase the diligence of their visual surveillance. Subsequently, if no marine mammals are visually detected, then the crew may continue multi-static active search.

(F) *Visual Detection*—If marine mammals are visually detected within 914 m (1,000 yd) of the explosive source sonobuoy (AN/SSQ–110A) intended for use, then that payload shall not be detonated. Aircrews may utilize this post once the marine mammals have not been re-sighted for 30 minutes, or are observed to have moved outside the 914 m (1,000 yd) safety buffer. Aircrews may shift their multi-static active search to another post, where marine mammals are outside the 914 m (1,000 yd) safety buffer.

(G) Aircrews shall make every attempt to manually detonate the unexploded charges at each post in the pattern prior to departing the operations area by using the ''Payload 1 Release'' command followed by the ''Payload 2 Release'' command. Aircrews shall refrain from using the ''Scuttle'' command when two payloads remain at a given post. Aircrews will ensure that a 914 m (1,000 yd) safety buffer, visually clear of marine mammals, is maintained around each post as is done during active search operations.

(H) Aircrews shall only leave posts with unexploded charges in the event of a sonobuoy malfunction, an aircraft system malfunction, or when an aircraft must immediately depart the area due to issues such as fuel constraints, inclement weather, and in-flight emergencies. In these cases, the sonobuoy will self-scuttle using the secondary or tertiary method.

(I) The Navy shall ensure all payloads are accounted for. Explosive source sonobuoys (AN/SSQ–110A) that can not be scuttled shall be reported as unexploded ordnance via voice communications while airborne, then upon landing via naval message.

(J) Mammal monitoring shall continue until out of own-aircraft sensor range.

(viii) Memorandum of Agreement (MOA)

The Navy and NMFS shall develop an MOA, or other mechanism consistent with Federal fiscal law requirements (and all other applicable laws), that allows the Navy to assist NMFS with the Phase 1 and 2 Investigations of USEs through the provision of in-kind services, such as (but not limited to) the use of plane/boat/truck for transport of personnel involved in the stranding response or investigation or animals, use of Navy property for necropsies or burial, or assistance with aerial surveys to discern the extent of a USE. The Navy may assist NMFS with the Investigations by providing one or more of the in-kind services outlined in the MOA, when available and logistically feasible and when the assistance does not negatively affect Fleet operational commitments.

(b) [Reserved]

§ 218.115 Requirements for monitoring and reporting.

(a) The Navy is required to cooperate with the NMFS, and any other Federal, State or local agency monitoring the impacts of the activity on marine mammals.

(b) *General Notification of Injured or Dead Marine Mammals*—Navy personnel shall ensure that NMFS is notified immediately ((*see* Communication Plan) or as soon as clearance procedures allow) if an injured, stranded, or dead marine mammal is found during or shortly after, and in the vicinity of, any Navy training exercise utilizing MFAS, HFAS, or underwater explosive detonations. The Navy will provide NMFS with species or description of the animal(s), the condition of the animal(s) (including carcass condition if the animal is dead), location, time of first discovery, observed behaviors (if alive), and photo or video (if available). In the event that an injured, stranded, or dead marine mammal is found by the Navy that is not in the vicinity of, or during or shortly after, MFAS, HFAS, or underwater explosive detonations, the Navy will report the same information as listed above as soon as operationally feasible and clearance procedures allow.

(c) *General Notification of Ship Strike*—In the event of a ship strike by any Navy vessel, at any time or place, the Navy shall do the following:

(1) Immediately report to NMFS the species identification (if known), location (lat/long) of the animal (or the strike if the animal has disappeared), and whether the animal is alive or dead (or unknown)

(2) Report to NMFS as soon as operationally feasible the size and length of animal, an estimate of the injury status (ex., dead, injured but alive, injured and moving, unknown, *etc.*), vessel class/type and operational status.

(3) Report to NMFS the vessel length, speed, and heading as soon as feasible.

(4) Provide NMFS a photo or video, if equipment is available

(d) *Event Communication Plan*—The Navy shall develop a communication plan that will include all of the communication protocols (phone trees, *etc.*) and associated contact information required for NMFS and the Navy to carry out the necessary expeditious communication required in the event of a stranding or ship strike, including as described in the proposed notification measures above.

(e) The Navy must conduct all monitoring and/or research required under the Letter of Authorization including abiding by the NWTRC Monitoring Plan (*http://www.nmfs.noaa.gov/pr/permits/incidental.htm#applications*)

(f) *Report on Monitoring required in paragraph (c) of this section*—The Navy shall submit a report annually on September 1 describing the implementation and results (through June 1 of the same year) of the monitoring required in paragraph (c) of this section. Navy will standardize data collection methods across ranges to allow for comparison in different geographic locations.

(g) *Annual NWTRC Report*—The Navy will submit an Annual NWTRC Report on October 1 of every year (covering data gathered through August 1). This report shall contain the subsections and information indicated below.

(1) *ASW Summary*—This section shall include the following information as summarized from non-major training exercises (unit-level exercises, such as TRACKEXs and MIW):

(i) *Total Hours*—Total annual hours of each type of sonar source (along with explanation of how hours are calculated for sources typically quantified in alternate way (buoys, torpedoes, *etc.*))

(ii) *Cumulative Impacts*—To the extent practicable, the Navy, in coordination with NMFS, shall develop and implement a method of annually reporting non-major training (*i.e.*, ULT) utilizing hull-mounted sonar. The report shall present an annual (and seasonal, where practicable) depiction of non-major training exercises geographically across NWTRC. The Navy shall include (in the NWTRC annual report) a brief annual progress update on the status of the development of an effective and unclassified method to report this information until an agreed-upon (with NMFS) method has been developed and implemented.

(h) *Sinking Exercises (SINKEXs)*—This section shall include the following information for each SINKEX completed that year:

(1) Exercise Info;

(i) Location;

(ii) Date and time exercise began and ended;

(iii) Total hours of observation by watchstanders before, during, and after exercise;

(iv) Total number and types of rounds expended/explosives detonated;

(v) Number and types of passive acoustic sources used in exercise;

(vi) Total hours of passive acoustic search time;

(vii) Number and types of vessels, aircraft, *etc.,* participating in exercise;

(viii) Wave height in feet (high, low and average during exercise); and

(ix) Narrative description of sensors and platforms utilized for marine mammal detection and timeline illustrating how marine mammal detection was conducted

(2) Individual Marine Mammal Observation during SINKEX (by Navy Lookouts) Information

(i) Location of sighting;

(ii) Species (if not possible—indication of whale/dolphin/pinniped);

(iii) Number of individuals;
(iv) Calves observed (y/n);
(v) Initial detection sensor;
(vi) Length of time observers maintained visual contact with marine mammal;
(vii) Wave height;
(viii) Visibility;
(ix) Whether sighting was before, during, or after detonations/exercise, and how many minutes before or after;
(x) Distance of marine mammal from actual detonations (or target spot if not yet detonated)—use four categories to define distance:
(A) The modeled injury threshold radius for the largest explosive used in that exercise type in that OPAREA (TBD m for SINKEX in NWTRC);
(B) The required exclusion zone (1 nm for SINKEX in NWTRC);
(C) The required observation distance (if different than the exclusion zone (2 nm for SINKEX in NWTRC); and
(D) Greater than the required observed distance. For example, in this case, the observer would indicate if < TBD m, from 738 m − 1 nm, from 1 nm − 2 nm, and > 2 nm.
(xi) *Observed behavior*—Watchstanders will report, in plain language and without trying to categorize in any way, the observed behavior of the animals (such as animal closing to bow ride, paralleling course/speed, floating on surface and not swimming *etc.*), including speed and direction.
(xii) *Resulting mitigation implementation*—Indicate whether explosive detonations were delayed, ceased, modified, or not modified due to marine mammal presence and for how long.
(xiii) If observation occurs while explosives are detonating in the water, indicate munitions type in use at time of marine mammal detection.
(i) Improved Extended Echo-Ranging System (IEER) Summary
(1) Total number of IEER events conducted in NWTRC;
(2) Total expended/detonated rounds (buoys); and
(3) Total number of self-scuttled IEER rounds.
(j) *Explosives Summary*—The Navy is in the process of improving the methods used to track explosive use to provide increased granularity. To the extent practicable, the Navy shall provide the information described below for all of their explosive exercises. Until the Navy is able to report in full the information below, they will provide an annual update on the Navy's explosive tracking methods, including improvements from the previous year.
(1) Total annual number of each type of explosive exercise (of those identified as part of the ''specified activity'' in this final rule) conducted in NWTRC; and
(2) Total annual expended/detonated rounds (missiles, bombs, *etc.*) for each explosive type.
(k) *NWTRC 5-Yr Comprehensive Report*—The Navy shall submit to NMFS a draft report that analyzes and summarizes all of the multi-year marine mammal information gathered during ASW and explosive exercises for which annual reports are required (Annual NWTRC Exercise Reports and NWTRC Monitoring Plan Reports). This report will be submitted at the end of the fourth year of the rule (November 2013), covering activities that have occurred through June 1, 2013.
(l) *Comprehensive National ASW Report*—By June, 2014, the Navy shall submit a draft National Report that analyzes, compares, and summarizes the active sonar data gathered (through January 1, 2014) from the watchstanders and pursuant to the implementation of the Monitoring Plans for the Northwest Training Range Complex, the Southern California Range Complex, the Atlantic Fleet Active Sonar Training, the Hawaii Range Complex, the Marianas Islands Range Complex, and the Gulf of Alaska.

§ 218.116 Applications for Letters of Authorization.

To incidentally take marine mammals pursuant to these regulations, the U.S. Citizen (as defined by § 216.103) conducting the activity identified in § 218.110(c) (*i.e.*, the Navy) must apply for and obtain either an initial Letter of Authorization in accordance with § 218.117 or a renewal under § 218.118.

§ 218.117 Letters of Authorization.

(a) A Letter of Authorization, unless suspended or revoked, will be valid for a period of time not to exceed the period of validity of this subpart, but must be renewed annually subject to annual renewal conditions in § 218.118.
(b) Each Letter of Authorization shall set forth:
(1) Permissible methods of incidental taking;
(2) Means of effecting the least practicable adverse impact on the species, its habitat, and on the availability of the species for subsistence uses (*i.e.*, mitigation); and
(3) Requirements for mitigation, monitoring and reporting.
(c) Issuance and renewal of the Letter of Authorization shall be based on a determination that the total number of marine mammals taken by the activity as a whole will have no more than a negligible impact on the affected species or stock of marine mammal(s).

§ 218.118 Renewal of Letters of Authorization and adaptive management.

(a) A Letter of Authorization issued under § 216.106 and § 218.177 of this chapter or the activity identified in § 218.170(c) will be renewed annually upon:
(1) Notification to NMFS that the activity described in the application submitted under § 218.246 will be undertaken and that there will not be a substantial modification to the described work, mitigation or monitoring undertaken during the upcoming 12 months;
(2) Receipt of the monitoring reports and notifications within the indicated timeframes required under § 218.115(b through j); and
(3) A determination by the NMFS that the mitigation, monitoring and reporting measures required under § 218.114 and the Letter of Authorization issued under §§ 216.106 and 218.117 of this chapter, were undertaken and will be undertaken during the upcoming annual period of validity of a renewed Letter of Authorization.
(b) *Adaptive Management*—Based on new information, NMFS may modify or augment the existing mitigation measures if new data suggests that such modifications would have a reasonable likelihood of reducing adverse effects to marine mammals and if the measures are practicable. Similarly, NMFS may coordinate with the Navy to modify or augment the existing monitoring requirements if the new data suggest that the addition of a particular measure would likely fill in a specifically important data gap. The following are some possible sources of new and applicable data:
(1) Results from the Navy's monitoring from the previous year (either from the NWTRC or other locations);
(2) Results from specific stranding investigations (either from the NWTRC Range Complex or other locations, and involving coincident MFAS/HFAS training or not involving coincident use) or NMFS' long term prospective stranding investigation discussed in the preamble to this proposed rule;
(3) Results from general marine mammal and sound research (funded by the Navy or otherwise);
(4) Any information which reveals that marine mammals may have been taken in a manner, extent or number not authorized by these regulations or subsequent Letters of Authorization.
(c) If a request for a renewal of a Letter of Authorization issued under §§ 216.106 and 218.118 of this chapter indicates that a substantial modification to the described work, mitigation or

monitoring undertaken during the upcoming season will occur, or if NMFS utilizes the adaptive management mechanism addressed in paragraph (b) of this section to modify or augment the mitigation or monitoring measures, the NMFS shall provide the public a period of 30 days for review and comment on the request. Review and comment on renewals of Letters of Authorization would be restricted to:

(1) New cited information and data indicating that the determinations made in this document are in need of reconsideration, and

(2) Proposed changes to the mitigation and monitoring requirements contained in these regulations or in the current Letter of Authorization.

(d) A notice of issuance or denial of a renewal of a Letter of Authorization will be published in the **Federal Register**.

§ 218.119 Modifications to Letters of Authorization.

(a) Except as provided in paragraph (b) of this section, no substantive modification (including withdrawal or suspension) to the Letter of Authorization by NMFS, issued pursuant to §§ 216.106 and 218.117 of this chapter and subject to the provisions of this subpart, shall be made until after notification and an opportunity for public comment has been provided. For purposes of this paragraph, a renewal of a Letter of Authorization under § 218.118, without modification (except for the period of validity), is not considered a substantive modification.

(b) If the Assistant Administrator determines that an emergency exists that poses a significant risk to the well-being of the species or stocks of marine mammals specified in § 218.110(b), a Letter of Authorization issued pursuant to §§ 216.106 and 218.117 of this chapter may be substantively modified without prior notification and an opportunity for public comment. Notification will be published in the **Federal Register** within 30 days subsequent to the action.

[FR Doc. E9–16301 Filed 7–10–09; 8:45 am]

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H.R. 1777/P.L. 111–39

To make technical corrections to the Higher Education Act of 1965, and for other purposes. (July 1, 2009; 123 Stat. 1934)

S. 614/P.L. 111–40

To award a Congressional Gold Medal to the Women Airforce Service Pilots (''WASP''). (July 1, 2009; 123 Stat. 1958)

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